SENATE—*Tuesday, August 16, 1994*

(Legislative day of Thursday, August 11, 1994)

The Senate met at 9:15 a.m., on the expiration of the recess, and was called to order by the Honorable CAROL MOSELEY-BRAUN, a Senator from the State of Illinois.

PRAYER

The Chaplain, the Reverend Richard C. Halverson, D.D., offered the following prayer:

Let us pray:

Righteousness exalteth a nation: but sin is a reproach to any people.—Proverbs 14:34.

Eternal God, Lord of Heaven and Earth, Ruler of the nations, help us comprehend the faith of our fathers upon which they founded this great Nation.

In his address to the first joint session of Congress in Washington on November 22, 1800, John Adams said, "I congratulate the people of the United States on the assembling of Congress at the permanent seat of their Government; and I congratulate you, gentlemen, on the prospect of a residence not to be changed * * *. May this Territory be the residence of virtue and happiness!" Adams said, "Our Constitution was designed only for a moral and religious people. It is wholly inadequate for the government of any other."

Patient Lord, history teaches us that great empires like Rome fell, not because they were conquered from without, but because they disintegrated from within. Awaken us to the sheer necessity for a mighty visitation of God which will lead to spiritual and moral renewal, lest our Nation perish as the great empires of the past.

In the name of God and for the renewal of our land. Amen.

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore [Mr. BYRD].

The assistant legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, August 16, 1994.

To the Senate:

Under the provisions of rule I, section 3, of the Standing Rules of the Senate, I hereby appoint the Honorable CAROL MOSELEY-BRAUN, a Senator from the State of Illinois, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Ms. MOSELEY-BRAUN thereupon assumed the chair as Acting President pro tempore.

RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

MORNING BUSINESS

The ACTING PRESIDENT pro tempore. Under the previous order, there will now be a period for the transaction of morning business not to extend beyond the hour of 9:30 a.m., with Senators permitted to speak therein for not to exceed 5 minutes each.

The Senator from Ohio is recognized to speak for up to 15 minutes.

JUDGE SENTELLE-KENNETH STARR

Mr. METZENBAUM. Madam President, last Monday I addressed my colleagues to express my strong concern over the replacement of Robert Fiske with Kenneth Starr as the independent counsel in the Whitewater matter.

Today I rise to elaborate upon that matter, to discuss further the whole question of Judge Sentelle and his remaining in the position of continuing to make appointments in connection with the Whitewater investigation or any other independent counsel appointment. I believe that Judge Sentelle does, himself, fail to bring to the process that aura of impartiality that is so imperative if this process is to proceed forward as was originally contemplated by Senators LEVIN and COHEN when they introduced the legislation, and it was passed.

My opposition to the appointment was not because there was anything particularly wrong with Mr. Starr when Judge Sentelle appointed him, but because the whole process just looked horrible.

In fact, when Mr. Fiske was replaced, no one alleged that he did anything wrong. Two letters, one sent by Senator FAIRCLOTH to Attorney General Reno and another sent by 10 conservative Republican Congresspersons to Judge Sentelle, argued that Mr. Fiske had to be replaced in order to prevent an appearance of impropriety. And that is the subject to which I wish to address myself: The appearance of impropriety.

It was the appearance of impropriety that was the problem. So how was this appearance problem resolved? I came to the floor last week to express my concern that the appointment of Mr. Starr by Judge Sentelle created its own appearance problems.

First, look at the man who was chosen to replace Mr. Fiske. Kenneth Starr is not just an ordinary Republican. He is a highly partisan Republican who recently considered running for the Senate and who has taken a highly visible legal stance against the President of the United States. He was appointed to the bench by President Reagan, was Solicitor General for President Bush, contributed heavily to House and Senate Republican candidates and currently is cochairing the campaign of a Republican challenger who has built his campaign on attacking President Clinton. What is the appearance of this?

Never before in the history of the independent counsel has an appointee had an active role in a political campaign at the time of his selection. Never before has an appointee been this politically partisan.

Now let us look at the judge who appointed Starr—Judge Sentelle—serving on the independent counsel panel at the request of Chief Justice Rehnquist, appointed to the Federal bench by President Reagan, sponsored by Senator JESSE HELMS and judicial protector of Oliver North.

As if these appearance problems with Mr. Starr and Judge Sentelle were not enough, recently we have learned even more. It appears that at the time Judge Sentelle was deciding who would be Mr. Fiske's replacement, he was meeting on Capitol Hill with two of the most vociferous critics of the Clinton administration and the Whitewater matter. Now, how does that look? We are talking about the appearance of impropriety, and how can you possibly explain that kind of contradiction, or at least that kind of meeting, in view of the so-called appearance of impropriety?

A judge who is charged with selecting an impartial and independent counsel—one free from political influence—should not appear to be subject to political influence himself. Surely, Judge Sentelle should have known better. He should have been sensitive enough to appearances of partisanship to realize that he had no business meeting with two conservative Republican friends, one of whom was spearheading the effort to replace Mr. Fiske. What are Americans supposed to think of a judge, who is charged with maintaining

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

impartiality, appearing to consort with the leading critics of the opposing political faction?

This meeting, regardless of what was discussed, destroys any remaining hope of an appearance of impartiality. Even if the independent counsel matter was not discussed—and I have no way of knowing whether it was or was not—the mere presence of these men together at that time raises a highly disturbing appearance of impropriety.

How in the world, I ask my colleagues, can this have the appearance of impartiality? How can the American people possibly have faith in the independence of the special counsel responsible for such a highly sensitive political investigation of the President under these circumstances?

That is now impossible. There is no other way to slice it. It is impossible to deny the appearance of—not of impropriety—of impartiality. It is clear that if what my Republican colleagues were concerned about with Mr. Fiske was the appearance of impartiality, then what we have here is an appearance problem from beginning to end. Judge Sentelle's pick of Kenneth Starr has a much worse appearance problem than anything—than anything—alleged about Mr. Fiske.

Perhaps even more important, Madam President, is the threat that this appointment process poses to the independent counsel law. That law was originally enacted in the best bipartisan spirit, a tremendous effort, led in the Senate by Senator LEVIN and Senator COHEN, and the Members of the Congress owe them a debt of gratitude for fashioning that law in such a way so that, indeed, there could be an independent counsel that was truly independent.

The whole thought behind the original act was to protect the independent counsel process from partisan influence and to promote the fairness of investigations. The whole reason judges were accorded the decision as to the selection of an independent counsel is because they are supposed to be immune from political influence and able to maintain public confidence in a fair process. The replacement of Mr. Fiske with Mr. Starr by Judge Sentelle makes a mockery of the independent counsel law.

We must act to protect the statute's purposes. We must start from a clean slate. In order to protect the appearance of impartiality, Kenneth Starr should either resign his appointment or be removed from the post.

In addition—and this, I believe, is probably as important as anything that I have said up until this point—before Judge Sentelle has another chance to taint the appearance of another appointment, he should either step down or be removed from the judicial panel that selects independent counsels, for the same reason.

I understand that Judge Sentelle is involved at this very time in selecting the independent counsel to handle the Mike Espy investigation and would continue to make such appointments in the future.

In light of the appearance of partisanship he has displayed in the Starr appointment, the American people cannot accept his continued involvement as head of the independent counsel panel.

I am sure that there are hundreds of eminent lawyers out there—Democrats and Republicans alike and maybe some Independents as well—who could be trusted as nonpartisan, independent counsel. And I am confident that Chief Justice Rehnquist would be able to find another judge—I do not care whether he or she is a Democrat or a Republican—who could fill Judge Sentelle's position on the panel without creating the appearance of partisanship.

I believe that Justice Rehnquist has some responsibility in this matter, and I would call upon him to reexamine the propriety of Judge Sentelle continuing to head up the panel choosing the independent counsel in this instance, as well as possibly future ones.

The American people can no longer trust in the integrity and fairness of this independent counsel investigation. The law was fashioned correctly, and the operation of the law was supposed to work well. But at this moment, there appears to be nothing independent about it. It reeks of partisanship, and the American people know it. Actions must be taken to restore the public's confidence in this most important matter and in the overall integrity of the independent counsel process.

Madam President, I yield back the remainder of my time.

Mr. GRASSLEY addressed the Chair.

The ACTING PRESIDENT pro tempore. The Senator from Iowa.

EXTENSION OF MORNING BUSINESS

Mr. GRASSLEY. Madam President, I ask unanimous consent to address the Senate in morning business for 6 minutes, and I ask that the time be extended beyond 9:30 to that extent.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

NOMINATION OF LT. GEN. MICHAEL RYAN

Mr. GRASSLEY. Madam President, I want to speak in support of a pending nomination that I do not know exactly when it is going to come up because nominations of this type come up very quickly and usually at the close of business.

Madam President, I would like to speak in support of the pending nomination of Air Force Lt. Gen. Michael Ryan.

General Ryan is currently the Assistant to the Chairman of the Joint Chiefs of Staff.

He has been nominated to be "dual-hatted" as commander, Allied Air Forces, Southern Europe, NATO, and commander, 16th Air Force, U.S. Air Force, Europe.

I would like to speak on General Ryan's nomination because it has a direct bearing on the pending nomination of Lt. Gen. Buster C. Glosson.

General Glosson got in hot water for allegedly having improper communications with three members of the 1993 major general promotion board and then allegedly lying about it when questioned by investigators.

Well, General Ryan was a member of that selection board.

He and two other senior officers formally complained that General Glosson had communicated with each of them separately regarding the integrity of a fellow officer whose name was before the board for consideration.

Improper communications with a promotion board are "expressly forbidden" by paragraph 11 of Air Force Regulation 36-9. The failure to obey this regulation could be a court-martial offense under the Uniform Code of Military Justice.

The Senate Armed Services Committee has worked very hard in recent years to bring some integrity to the military promotion process and most particularly to insulate promotion boards from improper influence.

The rules that were allegedly violated are a direct result of all the committee's hard work.

Because of the serious nature of complaints lodged against General Glosson, a joint investigation was launched by the Department of Defense inspector general and the Air Force IG.

The DOD IG was in charge and made all decisions regarding the scope and direction of the investigation.

All parties involved were questioned under oath. The evidence was evaluated and a joint report was issued on November 8, 1993.

The joint report was reviewed and approved by the Judge Advocate General and general counsel of the Air Force. The lawyers said: "The findings are supported by the evidence of record."

The principal evidence in the case against General Glosson is the testimony given by General Ryan and two other senior officers.

General Ryan testified that approximately 2 weeks after he had been officially notified and designated as a member of the selection board, General Glosson called him on the telephone.

General Ryan described the telephone conversation like this:

LTG Glosson related to me the following: That [General X] had lied to the Chief of Staff [General McPeak], and that the Chief

of Staff didn't want him promoted. I asked General Glosson, I said, let me see if I got this right. I was taken aback. [General X] lied to the Chief of Staff, and the Chief of Staff does not want [General X] promoted. And he says, That's it. And I said, I understand the message. And that was the end of the conversation. It was a very short conversation.

The IG investigators asked General Ryan if he thought General Glosson knew he was a member of the board when he called: "In your mind, were you convinced that he [General Glosson] knew you were a member of the board?"

General Ryan replied: "Oh yes, I'm sure."

The IG followed up: "No doubt of that."

General Ryan: "No doubt."

After General Glosson's telephone call, General Ryan testified that he felt "disturbed." He said:

After a point, it started festering in me * * * It really started bugging me * * * I don't think I can get through it * * * I can't sign that piece of paper and swear that I know of no attempt to influence the outcome of the board.

Madam President, officers who are assigned to such boards take a solemn oath to act without prejudice or partiality. And they have a duty to request relief if they think the board's proceedings have been somehow compromised.

After considerable anguish, General Ryan asked to be excused from the board. He related the substance of his telephone conversation with General Glosson to Secretary Widnall, and she subsequently excused him from the board.

General Glosson's testimony presents a somewhat different picture of what happened. General Glosson admitted he had the telephone conversation with General Ryan. General Glosson admitted that he questioned the integrity of General X during the conversation. General Glosson said General X "had lied" to him in the past. And he even admitted saying that "the chief can't trust" General X.

But that is where the similarities ended. General Glosson denied telling General Ryan that he and the chief did not want General X promoted, and he denied knowing that General Ryan was a member of the promotion board.

General McPeak's testimony did not help General Glosson. General McPeak denied that he ever told Glosson that General X was dishonest and should not be promoted.

Madam President, as I said a moment ago, the principal evidence in the case is the testimony of those involved.

What did General Glosson say to General Ryan and the other two officers about the fitness of General X for promotion to higher rank?

Did General Glosson say that Chief of Staff McPeak did not want General X promoted?

Did General Glosson know General Ryan and the others were members of the board when he spoke to them?

These issues are the focus of the testimony.

The testimony of General Ryan and the other two officers is almost identical about what General Glosson supposedly said.

General Glosson, by comparison, gives a very different version of what was said.

Madam President, it comes down to this: His word against theirs. There is no room for a mistake or misunderstanding. There is no way to resolve the conflicting testimony.

What we have here are irreconcilable accounts of what happened. There is just one inescapable conclusion: Somebody is lying.

The inspectors general found that General Ryan's account of his telephone conversation with General Glosson was almost identical in "timing, substance, and intent" with General Glosson's alleged communications with the other two officers.

General Ryan's version of General Glosson's comments was corroborated by the testimony of the other two senior officers, who said Glosson made similar statements to them. There is no evidence that Ryan or the others had a motive to lie.

There is not one shred of evidence to suggest that General Ryan and the others conspired to fabricate the allegations against General Glosson. What benefit could they possibly derive from doing that?

Quite to the contrary, General Ryan and the others came forward at great personal risk and with no certainty about what the final outcome might be.

The inspectors general believe that General Ryan is telling the truth. Everything points in that direction.

For these reasons, Madam President, I support General Ryan's pending nomination.

JUDGE SHERMAN G. FINESILVER STEPS DOWN AS CHIEF JUDGE IN U.S. DISTRICT COURT, COLORADO

Mr. BROWN. Madam President, I want to turn the attention of the U.S. Senate to a distinguished American: Chief Judge Sherman G. Finesilver of the U.S. District Court of Colorado.

On June 1, 1994, Chief Judge Finesilver took senior status. He will be sorely missed and difficult to replace on the active trial bench.

This does not mean a retirement, merely a change of status. Judge Finesilver will continue to handle a substantial case load and lend his expertise as a settlement judge for other judges in complex litigation—a field in which he is nationally known.

Judge Finesilver's contributions are as many as they are valued. In addition to an unusually sharp mind and an impressive command of the law, Judge Finesilver has a judicious demeanor. In the imposing Federal courtroom, litigants are all too often faced with a process that seems to either threaten the social good for legal technicalities or disregard legal principles for more popular decisions. Judge Finesilver is crafting a jurisprudence worthy of praise both for its legal acumen and its social worth.

In his 39 years of service on the bench, Judge Finesilver has made his mark—by humanizing the court, by solving complex legal matters, by facing the difficult cases and by lucidly explaining his decisions.

Judge Finesilver has served in the Federal and State judiciary for 39 years, the past 23 as a Federal judge. His judicial career dates back to 1953, when at age 28, he was appointed a county judge in Denver. He was elected to the district bench in 1962 and again in 1966. At each election he led the ticket among all candidates for any office in Denver. Judge Finesilver was appointed to the Federal bench in 1971 by President Nixon and in the length of active service in May, 1994, he became a senior trial judge on both the Federal and State benches in Colorado and in the Federal Tenth Circuit.

He has served as chief judge of the important U.S. Federal court for the past 12 years and he has been effective and accomplished. He is widely known for his skill as a trial judge, a national leader in effective court management, a master of trial settlement of complex litigation. He is held in high respect throughout the country as an effective chief judge. He is a widely sought after speaker in judicial, legal, and medically-related subjects. Because of his skill as a settlement master and trial judge, he has been appointed by the Chief Justice to serve in that capacity in Florida, Idaho, California, Puerto Rico, and 10 other Federal Districts.

By election of all judges in the tenth circuit, he was elected to serve on the Judicial Conference in the United States—the highest policymaking body in the Federal judiciary; he also was a member of the Judicial Council of the Tenth Circuit, Chair of the Chief Federal District Judges of the Tenth Circuit, Coordinating Council of Federal Native American Trial Judges in the Tenth Circuit.

Judge Finesilver has tried over 7,000 civil cases in Federal court and an additional 3,000 while a State district judge. He handled literally thousands of cases in service as a county judge, where his program established the driving improvement school—a national model the format of which has been used by the National Safety Council and American Association of Retired Persons.

His legal rulings in such diverse fields as discrimination in employment, oil shale, water law, massive disasters including aircraft, securities

law, intellectual property, have been heralded as learned, persuasive, and precedent-setting. Virtually all swine flu cases in the country are built on his opinions which resulted in development of the National Childhood Vaccine Act. His ruling in an harassment in employment case was the first of its kind in the Nation and prompted widespread changes to employment practices in the private and public sectors.

No doubt exists that Judge Finesilver's leadership in serving not only the intellectual demands of justice, but also the efficiency demands of justice mark his tenure as a widely known and respected jurist who has done much to humanize the Federal court system. His expertise at managing complex and difficult cases is renowned. He presided over 125 cases arising out of the swine flu vaccination program. Virtually all later cases built on the precedents he established. Judge Finesilver handled a major airplane crash case involving 28 fatalities and numerous injuries. The case was concluded within an unprecedented 1 year from the date of filing and 24 months from the date of the crash. The multifaceted Silverado litigation was brought to settlement within 12 months of filing. His managerial and judicial activity in a securities fraud case in northern Colorado resulted in investors receiving over 100 percent of their initial investments. This recovery is unparalleled in the United States. He concluded a massive environmental case at the Lowry landfill facility within 1 year.

In addition, his writings on legal, medical, and youth and citizenship-related fields have brought him a national reading audience. An excerpt of one of his speeches was published in Reader's Digest. His early career dealing with the legal rights of the deaf resulted in development of a model interpreter's law, which is a forerunner of laws in all State and Federal courts.

In his early years as a judge, Judge Finesilver was nationally recognized for his activity in dealing with enhancement of the legal rights of the deaf, physically impaired and aging, promoting their insurability and fair driver licensure. He was a driving force for the development of closed captioned television for hearing impaired persons on television broadcasting—a concept he began working on in the 1960's while dealing with the legal rights of the deaf and physically hearing impaired at the University of Denver College of Law.

Judge Finesilver, by Presidential appointment, has served on five national commissions and panels in aging, physically impaired, drunk drivers, traffic safety and recently, on the need for research in antisocial and aggressive behavior in the United States.

Judge Finesilver has been awarded honorary doctorates from Gallaudet College in Washington, DC, for his championship of the rights of the deaf, New York Law School for his pioneering role for the legislation of organ transplants, right of the deaf and physically handicapped, and the enlightened administrative justice. He has also achieved honorary doctorates from the University of Colorado and Metropolitan State College in Denver. He has also received the Norlin Award for outstanding alumni at the University of Colorado.

Colorado's Chief Judge also contributes to our State and our country when he leaves the bench and hangs up his robe. Outside the courtroom, Judge Finesilver has such notable accomplishments as the development of the Federal magistrate judge systems throughout the State of Colorado to make sure the courtroom door is always open, the establishment of a liaison between Federal and State judges and the drafting of a model criminal code for the Czech Republic.

These are just a few of the other noteworthy accomplishments.

Initiated community constituted naturalization programs—one featured former president Gerald Ford; youth were heavily involved in the program. The program was recognized by the Freedoms Foundation of Gettysburg, PA.

Served for over 20 years as chair, American Citizenship Committee of the Colorado Bar Association, which has as its focal point court visitations by school children with attorneys as tour leaders. One program contrasted United States judicial system with that of the U.S.S.R.; this program was honored by the Freedoms Foundation.

Principal author of monograph on community service—a new dynamic in criminal justice; monograph is used in all 94 Federal district courts and probation offices.

By personal involvement, encouraged manufacturer to donate 200 T-shirts to Denver low-income persons: shirts were confiscated from merchants who illegally obtained and distributed them.

One of the principal founders—and first chairman—of Minoru Yasui Community Volunteer Award, a monthly award given to recognize volunteer activities of Colorado residents. The monthly cash award is now $5,000, and the awardee determines the charity to receive this amount. Thus, many Denver charities have been beneficiaries of this unusual award. The M.Y.C.V.A. program served as a model for the J.C. Penney Community Award and television station KUSA's Nine Who Care Award.

Encouraged greater availability of judicial resources in ares of two Native Indian tribes in Durango and Cortez, CO; developed improved cooperation among tribal leaders, U.S. magistrate judges, U.S. attorney's office, Federal public defender's office, and local law enforcement.

Developed endangered species exhibit for display at Stapleton International Airport in Denver. Part of funds necessary for exhibit was obtained through fines assessed against persons convicted of Federal endangered species crimes. Exhibit was one of the first of its kind at an airport, seen by millions of travelers, and widely heralded by those interested in the preservation of endangered wildlife.

A Denver editorial noted his retirement as chief judge in these words:

> One of Finesilver's hallmarks on the bench has been proficient management—an uncanny ability to close cases and keep the docket moving—which he has seen as rapidly increasing in importance of late. Thus, not only did he keep the wheels of justice operating smoothly, he saved taxpayers some large sums of money.

Finesilver's career, however, cannot be adequately summed up in terms of quantity alone. The quality of his jurisprudence has been at least as notable. His emphasis on fairness, knowledge of the law, research skills, analytical acumen and articulation—all components of what is commonly called wisdom when applied to judges—are well known and respected.

It is also important to add dedication to that list of words. The son of a west side family of modest means who attended law school by night, Finesilver's judicial career began in Denver County Court in 1955, when he was only 28. He was elected to the State district bench in 1962 and 1966, and appointed by President Nixon to the Federal district bench in 1971.

Those two State elections were pivotal crossroads in his career. When he won those elections, Finesilver was considered one of Colorado's most electable individuals. That is to say, had Finesilver chosen to pursue politics at that time, the only likely direction for his career would have been upward.

But Finesilver avoided the greater visibility—and probably easier workload—of a political career in favor of his chosen calling. He is a man who believes not only in the need for law, but in the honor and nobility of the legal profession itself.

"My heart still swells with pride," he wrote to President Clinton this week, "at the beginning of each court session when the court crier opens the court with these words—'God save the United States and this Honorable Court'."

Fortunately, Sherman Finesilver will still be hearing that clarion call for some time. Although stepping down as chief judge, he will remain a senior Federal judge, characteristically looking forward to handling a substantial number of cases. Also characteristically, he will devote increased time to such projects as helping research Native American tribal law—one of his personal passions—and in assisting the Czech Republic draft a criminal code.

But Finesilver also hopes to spend more time with his grandchildren, and

"fishing the mountain lakes and streams where over the years [he has] drowned, lost and snagged more than a million worms and prize fishing flies."

The following is a personal note by one of his former law clerks.

One can see him light up while performing the citizenship tasks of his judgeship. I'll never forget the truly special moments during my clerkship when Judge Finesilver performed the swearing-in ceremony for new American citizens, or when we conducted a mock trial to determine who stole the Halloween pumpkin for a local group of first graders. These are the acts of not only a sensitive and remarkable judge, but also a good citizen. Although, I have known Judge Finesilver for only a few of his thirty-eight years on the bench, I stand with the many who have known him much longer in congratulating him on a lifetime of achievement as a judge, a leader, and "citizen" in the word's best sense. Congratulations, and thank you, Judge Finesilver.

On May 31, 1994, Judge Finesilver completed his last day as the chief judge. On that day, when the court crier called out "God save the United States and this Honorable Court," I imagine he really meant it.

DIVERSITY; TOLERANCE

Mr. BOREN. Madam President, a college classmate of mine, Phil Johnson, has just written a very interesting and instructive article on the challenges of diversity and the need for tolerance in our society. It was recently published in the journal Telecommunications, a publication of the Alliance for Telecommunications Industry. I am pleased to share it with my colleagues.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

MULTICULTURALISM: ITS PROMISE AND CHALLENGE TO COMMITTEE T1

(By Phil Johnson)

It is obvious that Diversity, Multiculturalism, or whatever politically correct term is in vogue, is a part of our daily lives—at home, in the work environment, in the greater society. And it is equally obvious that these pluralisms have been embraced, rightly I think, by Committee T1 and have added to the decade of success for Committee T1.

But I also think that a pre-condition, not well understood and not brought to conscious recognition, lie at the basis of this success. This pre-condition is a value, shared across the pluralities, to bring different views to debate and to find, through compromise, a place where, not optimal perhaps, consensus can be reached for a time. The shared belief that this scenario can occur is a testament of faith to the founding fathers of Committee T1 and to the company members and representatives of those members who live this belief day-to-day.

Perhaps seeing "Schindler's List" recently reminded me that Drucker's "Tyranny of the Minority" are silent for only a moment and, because of the pluralism we jointly support, we of Committee T1 always need to be at the ready to respond. These are the people of an ideology, and it is the consequences of an ideology that we must deal with. Those circumstances where we forget our common moorings in our accumulated, common humanity are always ready to present issues for us.

The issue—the opposite of Burke's circumstances—is that when timeless dogmas are allowed to run unconnected in time (or, to the accumulated experience and contending currents of humanity) an ideology encourages murder as easily as encourages claim of nobility. But the experience in the world and ours in T1 say that not all options are equally likely and, in fact, our reason for being is the development of reason as to why certain path(s) are preferable.

Why does any ideology tend to be authoritarian? Perhaps it is that any system of ideas that consciously purifies itself to previous context and claims to contain all value must also wish for complete control. Any scheme for regulating life that systematically asserts that it is internally and systematically complete must logically will to exercise its power completely, or its claims for itself are invalid. This self-righteousness is a function of this inferred self-perceived completeness. And, as I have mentioned earlier in these newsletters, these closed systems seduce us as being attractive because they are simple. I say that they are simple only because they are manipulations and evasions of the contradictory, gray, complex reality of the plurality of Committee T1 (and the larger society). And those who operate such systems are compelling because they are never in doubt.

This, I think, underlies the reason why organizations use process to develop. Use of process, so common and yet so taken for granted within Committee T1 and elsewhere, allows solutions to develop in a plurality where, as Alex Bickal put it, "Where values are provisionally held, are tested and evolve within the legal order—derived from the morality of the process, which is the morality of consent."

This commitment to believing in process does in no way mean that one does not hold dear beliefs in equality, in social justice, in the reward of merit and in freedom itself. One must have convictions, but also must be willing to submit these beliefs to the testing and tumult of the process. What binds us together as free women and men—as Americans—is a shared faith in those processes by which we evolve and test our several beliefs and traditions. Fear the self-inflicted blindness of self-righteousness and find truth in that construct where means and process live.

"Circumstances * * * give in reality to every political principle its distinguishing color and discriminating effect. The circumstances are what render every civil and political scheme beneficial or noxious to mankind."—EDMUND BURKE, "Reflections on the Revolution."

CARL ANDREW WARREN

Mr. MITCHELL. Madam President, on August 4, 1994, Carl Andrew Warren, an employee of the Sergeant at Arms and Doorkeeper of the Senate, passed away.

Mr. Warren served the Federal Government for almost 35 years. In 1958, he was drafted into the Army. After completing his tour of duty, he worked in the Senate Restaurant as a banquet porter. In 1964, Mr. Warren joined the staff of the Sergeant at Arms.

Initially hired as a skilled laborer, Mr. Warren was promoted to the position of assistant night foreman in the Environmental Service Department. Mr. Warren's primary responsibility was the care and maintenance of the Minton tile floors located throughout the Senate wing of the U.S. Capitol. He was a dedicated and loyal employee, who took great pride in his work. Countless visitors to the Capitol have admired the colorful tile floors and the fine maintenance Mr. Warren provided.

I know all Members of the Senate share my appreciation of Carl Andrew Warren's years of service and join me in extending our deepest sympathies to his mother, stepfather, and seven brothers and sisters.

BUDGET SCOREKEEPING REPORT

Mr. SASSER. Madam President, I hereby submit to the Senate the budget scorekeeping report prepared by the Congressional Budget Office under section 308(b) and in aid of section 311 of the Congressional Budget Act of 1974, as amended. This report meets the requirements for Senate scorekeeping of section 5 of Senate Concurrent Resolution 32, the first concurrent resolution on the budget for 1986.

This report shows the effects of congressional action on the budget through August 13, 1994. The estimates of budget authority, outlays, and revenues, which are consistent with the technical and economic assumptions of the concurrent resolution on the budget (H. Con. Res. 287), show that current level spending is below the budget resolution by $2.6 billion in budget authority and $1 billion in outlays. Current level is $0.1 billion above the revenue floor in 1994 and below by $30.3 billion over the 5 years, 1994–98. The current estimate of the deficit for purposes of calculating the maximum deficit amount is $311.7 billion, $1.1 billion below the maximum deficit amount for 1994 of $312.8 billion.

Since the last report, dated August 9, 1994, Congress has approved for the President's signature the Aviation Infrastructure Investment Act (H.R. 2739), and the Foreign Assistance Appropriations Act (H.R. 4426). These actions changed the current level of budget authority and outlays.

There being no objection, the report was ordered to be printed in the RECORD, as follows:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, August 15, 1994.

Hon. JIM SASSER,
Chairman, Committee on the Budget, U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The attached report shows the effects of Congressional action on the 1994 budget and is current through August 13, 1994. The estimates of budget authority, outlays, and revenues are consistent with the technical and economic assumptions of the Concurrent Resolution on the Budget (H. Con. Res. 64). This report is submitted under Section 308(b) and in aid of Section 311 of the Congressional Budget Act, as

amended, and meets the requirements for Senate scorekeeping of Section 5 of S. Con. Res. 32, the 1986 First Concurrent Resolution on the Budget.

Since my last report, dated August 8, 1994, Congress has approved for the President's signature the Aviation Infrastructure Investment Act (H.R. 2739), and the Foreign Assistance Appropriations Act (H.R. 4426). These actions changed the current level of budget authority and outlays.

Sincerely,

JAMES L. BLUM
(For Robert D. Reischauer).

THE CURRENT LEVEL REPORT FOR THE U.S. SENATE FISCAL YEAR 1994, 103D CONGRESS, 2D SESSION, AS OF CLOSE OF BUSINESS AUG. 13, 1994

[In billions of dollars]

	Budget resolution (H. Con. Res. 64)[1]	Current level[2]	Current level over/ under resolution
ON—BUDGET			
Budget authority	1,223.2	1,220.7	−2.6
Outlays	1,218.1	1,217.2	−1.0
Revenues:			
1994	905.3	905.4	0.1
1994–98	5,153.1	5,122.8	−30.3
Maximum deficit amount	312.8	311.7	−1.1
Debt subject to limit	4,731.9	4,558.4	−173.5
OFF—BUDGET			
Social Security Outlays:			
1994	274.8	274.8	.....
1994–98	1,486.5	1,486.5	.....
Social Security Revenues:			
1994	336.3	335.2	−1.1
1994–98	1,872.0	1,871.4	−0.6

[1] Reflects revised allocation under section 9(g) of H. Con. Res. 64 for the Deficit-Neutral reserve fund.

[2] Current level presents the estimated revenue and direct spending effects of all legislation that Congress has enacted or sent to the President for his approval. In addition, full-year funding estimates under current law are included for entitlement and mandatory programs requiring annual appropriations even if the appropriations have not been made. The current level of debt subject to limit reflects the latest U.S. Treasury information on public debt transactions.

Less than $50 million.

Note: Detail may not add due to rounding.

THE ON-BUDGET CURRENT LEVEL REPORT FOR THE U.S. SENATE, 103D CONGRESS, 2D SESSION, SENATE SUPPORTING DETAIL FOR FISCAL YEAR 1994, AS OF CLOSE OF BUSINESS AUG. 13, 1994

[In millions of dollars]

	Budget authority	Outlays	Revenues
ENACTED IN PREVIOUS SESSIONS			
Revenues	.....	.....	905.429
Permanents and other spending legislation[1]	721,182	694,713	.....
Appropriation legislation	742,749	758,885	.....
Offseting receipts	(237,226)	(237,226)	.....
Total previously enacted	1,226,705	1,216,372	905.429
ENACTED THIS SESSION			
Emergency Supplemental Appropriations, FY 1994 (P.L. 103–211)	(2,286)	(248)	.....
Federal Workforce Restructuring Act (P.L. 103–226)	48	48	.....
Offsetting receipts	(38)	(38)	.....
Housing and Community Development Act (P.L. 103–233)	(410)	(410)	.....
Extending Loan Ineligibility Exemption for Colleges (P.L. 103–235)	5	3	.....
Foreign Relations Authorization Act (P.L. 103–236)	(2)	(2)	.....
Marine Mammal Protection Act Amendments (P.L. 103–238)	.....	4	.....
Airport Improvement Program Temporary Assistance Act (P.L. 103–260)	(65)	.....	.....
Federal Housing Administration Supplemental (P.L. 103–275)	(*)	(2)	.....
Total enacted this session	(2,748)	(645)	.....
PENDING SIGNATURE			
Aviation Infrastructure Investment Act (H.R. 2739)	2,170	.....	.....
Foreign Assistance Appropriations Act (H.R. 4426)	99	99	.....
Total pending signature	2,269	99	0

THE ON-BUDGET CURRENT LEVEL REPORT FOR THE U.S. SENATE, 103D CONGRESS, 2D SESSION, SENATE SUPPORTING DETAIL FOR FISCAL YEAR 1994, AS OF CLOSE OF BUSINESS AUG. 13, 1994—Continued

[In millions of dollars]

	Budget authority	Outlays	Revenues
ENTITLEMENTS AND MANDATES			
Budget resolution baseline estimates of appropriated entitlements and other mandatory programs not yet enacted[2]	(5,562)	1,326	.....
Total current level[3 4]	1,220,664	1,217,153	905,429
Total budget resolution	1,223,249	1,218,149	905,349
Amount remaining:			
Under budget resolution	2,585	996	.....
Over budget resolution	.....	.....	80

[1] Includes Budget Committee estimate of $2.4 billion in outlay savings for FCC spectrum license fees.

[2] Includes changes to baseline estimates of appropriated mandatories due to enactment of P.L. 103–66.

[3] In accordance with the Budget Enforcement Act, the total does not include $14,265 million in budget authority and $9,091 million in outlays in funding for emergencies that have been designated as such by the President and the Congress, and $757 million in budget authority and $291 million in outlays for emergencies that would be available only upon an official budget request from the President designating the entire amount as an emergency requirement.

[4] At the request of Budget Committee staff, current level does not include scoring of section 601 of P.L. 102–391.

*Less than $500 thousand.

Notes: Numbers in parentheses are negative. Detail may not add due to rounding.

TRIBUTE TO MARION CRANK

Mr. PRYOR. Mr. President, I rise today to pay special tribute to a great American and outstanding citizen of my home State of Arkansas, Mr. Marion Crank.

Marion has served in so many positions of responsibility that I cannot begin to list them all. He has spent a lifetime unselfishly sacrificing his time and energy for the betterment of his local community and his State. His untiring endeavors as a member of the Arkansas State House of Representatives won him the admiration of his colleagues and gained him the well-deserved position of speaker of the house. He has worked with legislative leaders from across the Nation to find solutions to difficult problems that have been shared by all our States.

Southwest Arkansas, in particular, owes a great deal of gratitude to Marion for his tireless efforts to recruit industry, to make safe drinking water available on a countywide basis, and to establish low-rent housing to those in need of a better place to live and raise their families. These are but a few examples of the projects and undertakings that Marion has cultivated, sustained, and helped to complete.

Marion, with his vision, prudence, and vigor, is an example of an exemplary public servant. As we strive to make a positive difference for the many generations to come, we would do well to learn from the example he has provided in his own career. I am proud to know Marion and even prouder that he is a true friend.

IS CONGRESS IRRESPONSIBLE? YOU BE THE JUDGE ABOUT THAT

Mr. HELMS. Madam President, anyone even remotely familiar with the U.S. Constitution knows that no President can spend a dime of Federal tax money that has not first been authorized and appropriated by Congres—both the House of Representatives and the U.S. Senate.

So when you hear a politician or an editor or a commentator declare that "Reagan ran up the Federal debt" or that "Bush ran it up," bear in mind that it was, and is, the constitutional duty and responsibility of Congress to control Federal spending. Congress has failed miserably in that task for about 50 years.

The fiscal irresponsibility of Congress has created a Federal debt which stood at $4,666,432,889,364.19 as of the close of business Monday, August 15. Averaged out, every man, woman, and child in America owes a share of this massive debt, and that per capita share is $17,898.87.

SHANNON HASTINGS TO COMPETE IN MISS AMERICA PAGEANT

Mr. SMITH. Madam President, I want to congratulate Miss New Hampshire 1994, Shannon Heather Hastings of Newport, NH, as she prepares to take part in the 1994 Miss America Pageant in Atlantic City, NJ, on September 17. We in the Granite State are proud to have Shannon represent us at this prestigious event.

Shannon, a 21-year-old senior majoring in theater at the University of New Hampshire, won the Kingston State Scholarship Pageant in May to become Miss New Hampshire. She is interested in a career in stage and film and has been active in many volunteer programs across the State.

Working with local police departments, Shannon has volunteered with D.A.R.E. [Drug Abuse Resistance Education], a program which provides law enforcement officials and teachers with an opportunity to work together to prevent drug abuse. In addition, Shannon developed and implemented a drug and alcohol prevention program called "Steppin Out and Up" in many of New Hampshire's schools and made presentations to numerous civic groups. She has also volunteered with the Special Olympics.

In addition to her volunteer efforts, Shannon has pursued her interest in theater. She first performed the role of Annie at the age of 10 in a professional summer stock theater. At Newport high school, she had a major role in the musical "Assassins." She was also a member of the Tri-M Music Honor Society and the All-State Chorus.

Shannon was active in athletics at Newport High School where she broke a 12-year triple jump record and earned varsity letters in track and

cheerleading. Through all of her civic, community and athletic endeavors, Shannon never let her studies fail. She was a member of the dean's list and graduated in the top 10 in her class.

Shannon is the daughter of Mr. and Mrs. Milton Hastings of Newport. She has a brother Jeffrey, age 24, who attends Plymouth State College. Her father is a production-control manager at Sturm Ruger Company in Newport and her mother has held lead roles in numerous community theater productions. Shannon has certainly followed in those footsteps.

Madam President, we send our best wishes to Shannon as she travels to Atlantic City next month to compete for the title of Miss America. She is an accomplished young woman and will be an outstanding representative of the Granite State. It is an honor to represent Shannon and her family in the U.S. Senate.

CRIME: SETTING THE RECORD STRAIGHT

Mr. DOLE. Madam President, I just want to take a few moments to set the record straight concerning a comment made by the distinguished majority leader, Senator MITCHELL, on last Sunday's "Meet the Press" news show and today by the distinguished Senator from Delaware, Senator BIDEN.

On "Meet the Press," Senator MITCHELL suggested that I had no right to complain about the huge amounts of social spending now contained in the crime bill since Senate Republicans offered prevention amendments to the crime bill last November. It is my understanding that Senator MITCHELL read from amendments offered by Senators DOMENICI, DANFORTH, and myself.

I will not speak of the Danforth and Domenici amendments, but I will say a few words about my amendment. My amendment had two purposes: First, to toughen the penalties for those who engage in gang-related violence, and second, to provide funding for "gang prevention" grants. The amendment passed by a bipartisan vote of 60 to 38.

As I understand it, the section of my amendment dealing with "gang prevention" was originally part of the crime bill reported out of the Judiciary Committee by the chairman of the committee, Senator BIDEN. The "prevention" language was crafted by Senator BIDEN, not by me or any other Senate Republican. In fact, I included the Biden language in my amendment in order to attract Democrat support for the tough antigang penalties.

Yes, there was a good deal of social spending in the crime bill passed by the Senate last November. But the Senate bill did not have the $1.8 billion local partnership act; or the $900 million model cities intensive grant program; or the $650 million youth employment and skills grant program; or most of the other multimillion-dollar social programs that have now become part of the conference report.

The bottom line is that the crime bill left the Senate with a price tag of $22 billion. The conference report now authorizes a staggering $33 billion, a 50-percent increase. Obviously, somewhere along the way, the crime bill was hijacked by the big-dollar social spenders. This is not the fault of Republicans. It is the fault of the liberal Democrats who dominated the conference committee.

WILLIAM D. WALKER RETIRES FROM THE FOREST SERVICE

Mr. BUMPERS. Madam President, I rise today to pay tribute to Bill Walker, an outstanding public servant from my State, who will soon retire from Government service after a distinguished 36-year career with the U.S. Forest Service in the Ouachita National Forest.

While in college, Bill began his career with the Forest Service as a forestry aide in the now-defunct Leaf River Ranger District in Hattiesburg, MS. After graduating from the school of forestry at Mississippi State University, Bill served as a forester in the Mena Ranger District in Arkansas, the Homochitto Ranger District in Mississippi, and TMA in the Neches Ranger District in Texas. In 1964, he was promoted to his first job as a ranger in the Oakmulgee Ranger District in Centerville, AL. He went on to serve as ranger on Boston Mountain in Ozark, AR, before landing in Hot Springs in 1974. One of his many accomplishments in the Ouachita National Forest was getting the timber program back on track after some difficult times in the late 1980's and early 1990's.

In addition to his commitment to public service, Bill is active in many civic organizations including the National Cubic Foot Committee, the Ozark Task Force Interdisciplinary Planning Team, the Lion's Club, the Society of American Foresters, the Arkansas Forestry Association, the Mississippi State University Alumni Association, the American Forestry Association, and the Elks Club. He also served as a member of the Arkansas Board of Registration for Foresters.

Because of his exemplary service, Bill received many honors and awards during his tenure with the agency. In 1992, he received both the Outstanding Forester of the Year for the Arkansas Division of the Society of American Foresters and the National Forest Products Timber Sale Award.

Madam President, it is truly a pleasure to recognize and honor the accomplishments of such a devoted public servant. Those of us who have worked with Bill over the years know he is the consummate professional. His hard work and dedication are legendary and has helped make the Ouachita one of the finest national forests in the system. I hope my colleagues will join me in extending our thanks and appreciation to Bill Walker.

STONINGTON BAPTIST CHURCH—200 YEARS OF MAKING A DIFFERENCE IN PENNSYLVANIA

Mr. WOFFORD. Madam President, I rise today to recognize the Stonington Baptist Church as it celebrates 200 years of service and faith in the Commonwealth of Pennsylvania.

This faith community was established on June 21, 1794 by Rev. John Patton and originally called Shamokin Baptist Church. The inspired theme of the founders' was Matthew 7:24–25:

> Anyone who hears my words and puts them into practice is like the wise man who built his house on rock. When the rainy season set in, the torrents came and the winds blew and buffeted his house. It did not collapse; it had been solidly set on rock.

In 1845 at a meeting held at the church the idea for establishing Bucknell University took shape. Having been president of Bryn Mawr College, I know well the tremendous impact Bucknell has had in Pennsylvania producing leaders in numerous fields.

Soon the Stonington Church will be dedicating a new addition under the able leadership of its pastor, Rev. J. Douglass Hallman, Sr. As it celebrates its bicentennial, I wish all of the congregation the very best and commend the church for its pioneering role in the history of our Commonwealth. Stonington Church has indeed been solidly set on rock and will continue to make a difference through a commitment to faith, service, and values for generations to come.

Madam President, I ask unanimous consent that an article from the Daily Item be included in the RECORD.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

[From the Daily Item]

CHURCH TO CELEBRATE ITS 200TH ANNIVERSARY

STONINGTON.—The Stonington Baptist Church, Hosta Road, will celebrate the 200th anniversary of its founding during a 10 a.m. service on Sunday.

Foster Furman of Northumberland, whose grandparents were church leaders in the late 1800s, will make a presentation of historic information. There will be music, and the Rev. J. Douglas Hallman will be preaching from the founders' theme verses, Matthew 7:24-25.

The church was founded June 21, 1794, by the Rev. John Patton who settled in Shamokin Township from Kent County, Del. He called it the Shamokin Baptist Church.

The first members were Edward Wilkinson, Benjamin and Mary Vastine, Joseph and Ann Richardson and John and Abigail Farnsworth. The congregation was affiliated with the Philadelphia Baptist Association.

In 1796, the first church building was erected along the Shamokin Creek on the site now occupied by the Deibler Station Bible

Church, Paxinos RD1. The land was donated by Edward Wilkinson. An offering of $62.02 was sent from the Philadelphia Association to help pay for materials. The nails were furnished by a local blacksmith.

In 1820, the Shamokin Baptist Church, along with several other newly founded Baptist congregations, formed the Northumberland Baptist Association. In 1845, the Northumberland Baptist Association's annual meeting was convened in the Shamokin Baptist Church.

During this meeting, a resolution was passed to "establish a Literary and Theological Institution in the State, soon afterwards located at Lewisburg," presently known as Bucknell University. The association also went on record as opposing slavery.

In 1865, the congregation voted to build a new church on the "Turnpike" now known as Hosta Road in Shamokin Township. It was built and dedicated in 1873 at the cost of $3,000.

In 1959, the name of the church was changed to Stonington Baptist Church, and incorporated under this name in 1982.

In 1983, the congregation dedicated a remodeled and enlarged sanctuary and Sunday School rooms. In September 1994 the congregation plans to dedicate the newest addition, now under construction, which will provide a fellowship hall, classrooms, kitchen, restrooms, nursery, foyer and offices.

Pastors of the church in recent years include the Rev. Russell Fry, the Rev. Forest Gass, the Rev. Warren Moyer, the Rev. Clyde Whary and the Rev. Clifford Bassett.

CONCLUSION OF MORNING BUSINESS

The ACTING PRESIDENT pro tempore. Morning business is closed.

HEALTH SECURITY ACT

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will now proceed to the consideration of S. 2351, the Health Security Act, which the clerk will report.

The assistant legislative clerk read as follows.

A bill (S. 2351) to achieve universal health insurance coverage, and for other purposes.

The Senate resumed consideration of the bill.

Pending:

Mitchell Amendment No. 2560, in the nature of a substitute.

Dodd Amendment No. 2561 (To Amendment No. 2560), to promote early and effective health care services for pregnant women and children.

The ACTING PRESIDENT pro tempore. The Senator from Massachusetts.

Mr. KENNEDY. Madam President, we do have an amendment dealing with children that is before the Senate.

I yield myself such time as I might use.

We have, as we understand, if not a time agreement, at least a general understanding that during the course of the debate we will have fair distribution of time. At least it would be my understanding that we would rotate back and forth with the Members who are here.

The ACTING PRESIDENT pro tempore. The Senator's understanding is correct.

Mr. KENNEDY. That would be the way I would urge my colleagues on this side to go through the course of the morning.

Madam President, we are still waiting to have some resolution or some conclusion to the amendment that has been offered by the Senator from Connecticut. I think many of us who are cosponsors and strong supporters of it hope that it would then be followed by measures in other areas where we could begin to develop some common ground, some common understanding, some bipartisan efforts.

We had in our own Committee on Labor and Human Resources about 15 major policy areas discussed in our mark up. On at least 11 of those we were able to develop bipartisan support, and I think even though we have had some differences on the floor as expressed over the period of the last 2 weeks as we have been debating this issue, many of us are still hopeful we will be able to find the common ground which the American people are expecting and which the American people deserve so that we can move forward.

I want to take just a few moments away from the issue of children to review very briefly with the Senate the central themes that we have been examining, Republicans and Democrats alike, over the period of these past 2 weeks and to see by identifying them and by also reviewing how the principal measures which are before the Senate—the Mitchell bill and the Dole bill—actually deal with those issues because they are central to the whole health care reform debate.

Hopefully, after we dispose of the issue of preventive health care for children in our country—something for which there is such a compelling need, and for which the case I think has been very convincingly made—and after we try to make some additional progress in the areas of disability, perhaps mental health, perhaps in some rural health issues, we then will come back and focus on really the overarching policy questions which we are going to have to debate.

It seems to me to be appropriate to begin to look at those issues as we have seen them being discussed over the period of the last 2 weeks, so that we can begin to focus on those measures more effectively and hopefully more thoughtfully and try to move ahead.

So, Madam President, the two overarching goals of health reform are strengthening our health insurance protection for those who have it now, and guaranteeing health security for all Americans. We want Americans who have health coverage now to know that it will be ongoing, that it will be continuing, and it will be strengthened with legislation that hopefully will be reported out of our Senate.

The central part of that effort must be insurance reform. We have talked about that so we can end the insurance companies' abuses and the flaws in the current system that have left too many Americans vulnerable. That is basically understood as cherry picking, the selection of the healthiest individuals and insuring those, and leaving others behind.

This is a goal shared by Republicans and Democrats alike. Virtually every speech which has been made on the floor has said that we should end preexisting exclusions, No. 1; guarantee Americans the right to choose their doctor, No. 2; end the cherry picking that allows the insurance companies to choose to insure only the young and the healthy, No. 3. No. 4, achieve affordability of coverage for all. No. 5, open up the Federal Employees Health Benefits Program so that every American can enjoy access to the same high-quality health plan that Members of the Senate have.

We Members have many plans available to choose from. I have a family policy. I pay $101 a month for that program, which is one of the best in this country. Many of us have felt, and felt strongly, that kind of availability ought to be there for other Americans. If it is good enough for the Members of the Senate and the House, and the 10 million other Americans who are Federal employees, including the President, it should be available to other Americans as well. In the Mitchell proposal we make that kind of program available to all Americans in the community rated pool.

When debate picks up today, we will hear discussions about layers of bureaucracy, and there will be maps and charts. But, access to the Federal Employees Program is one of the important features of the Mitchell proposal. We do not see a lot of charts or maps when any of our Members go and sign up for that program. We do not hear a lot of complaints about it. We do not hear a lot of complaints even in the course of this debate about how inadequate it has been for them personally or members of their family. So we have included that.

Another aspect was the guaranteed portability. So if you lose your job or change your job, you will not lose your coverage.

We must examine these lofty bipartisan goals: they have been repeated and repeated and repeated over the course of this debate. When we look at the two different proposals that are before the Senate, there really is only one that will achieve them. The Mitchell plan truly reforms health insurance to achieve these objectives. The Dole plan does not. In fact, if we read the fine print, the Dole plan is so riddled with loopholes that it should not be called

the American Option Plan, but rather the "American Insurance Company Protection Act."

I would like to review those items that we have outlined, and that have been mentioned by almost every Member who has spoken during the course of the debate so far.

First of all, on preexisting condition exclusions, they are still allowed. This is a matter of such importance and consequence to American families. We speak to it, even as a Member of the Senate who had a son 12 years old with cancer, who lost his leg to cancer and is now well, healthy, happy, and the father of a wonderful young daughter, and has a very important and meaningful career in terms of community service. That young man would not be able to purchase insurance as an individual in my State, and I believe in all States, unless they are part of a group.

There are millions of families like that who have what is called a preexisting condition—cancer, heart disease, diabetes, juvenile diabetes, lupus. You can name those different items. What we want to do is, in our overall health care program, say we are going to eliminate the preexisting conditions restriction.

Mr. REID. Will the Senator from Massachusetts yield for a question?

Mr. KENNEDY. I will be glad to.

Mr. REID. It is my understanding that the State of Hawaii would not be one of those States without universal coverage, and the Senator's son and others similarly situated would be automatically entitled to coverage in Hawaii. Is that not true?

Mr. KENNEDY. The Senator is correct. I appreciate the intervention. We have had a good deal of discussion about the whole Hawaiian experience, particularly as it relates not only to preexisting conditions, but also to children, and how well they do with regard to children's issues.

Mr. REID. I ask the Senator if he agrees with this statement: Even though Hawaii is the State that costs more than any other State, with a very high cost of living in Hawaii, does the Senator acknowledge that it has the lowest cost of health care of any place in the United States?

Mr. KENNEDY. The Senator is correct. If you look at the trend, since the implementation of the Hawaiian experience—and as the Senator knows, for example, they have twice the incidence of breast cancer—but much lower death rates from the disease. They have twice the visitation in terms of doctors and hospitalization, and an excellent recovery level.

In the proposal introduced by the Republican leader, treatment of preexisting conditions is not assured; there are still exclusions for all services. It says on page 80 in paragraph 4: The health plan may impose a limitation or exclusion of benefits relating to treatment of a condition based on the fact that the condition preexisted the effective date of the plan.

It provides, furthermore, in paragraph (a): The condition was diagnosed and treated during the 3-month period prior to the plan.

So if they were getting treated 3 months prior to the plan for heart disease or cancer, they are out.

Or, it says, limitation or exclusion extends for a period of not more than 6 months after the date of the enrollment. It means that if you get in the plan, and you need treatment for 6 months, all of your treatment that was related to the plan will not be included or paid for by the plan.

Then it continues. As we know, under the Mitchell bill, all the preexisting condition prohibitions are effectively eliminated. There is an open enrollment period where anyone will be able to enter without having consideration of any preexisting condition. There is an amnesty period where people would be able to come in, and then by the year 2000, the concept of preexisting condition is totally eliminated, as compared to the Dole proposal.

In the Dole proposal, they say the participating State may establish a limit on the number of new enrollees the health plan may accept during that amnesty period.

So not only do we have a situation which excludes individuals with preexisting conditions, but the number of individuals who will be able to enter the various plans are going to be subject to some State judgment, some agency that will be established within the State, that is going to make the judgment as to whether individuals will be permitted or will not be permitted to enroll in a health plan.

You can imagine who is going to have the ear of those various State agencies. Do you think it is going to be the public or the individuals that are going to be affected with preexisting conditions, or do you think that the insurance companies might have some interest in that particular question?

If you then go to page 81, they talk about: The reference to 3 months in paragraph 1(a) is deemed a reference to 6 months. So they have a description about 3 months, and then in a later page they say any reference to 3 months is 6 months, and any reference to 6 months is deemed a reference to 12 months.

So I daresay, Madam President, that those who are most concerned about the preexisting conditions, comparing the two different proposals, have to reach very simple and clear conclusions.

Second, on the issue of the guaranteed choice of doctor, we have seen in the Mitchell proposal that co-ops and employers must provide a choice of plans, including the fee-for-service plan, which is basically the choice of doctors. That is explicit on page 136.

In the Dole bill, you can examine all 600 pages and there is no reference to how individuals are going to be able to have the free selection of doctors. It is not mentioned on page 96 in the section on cooperatives. It is not mentioned in the references to employers on page 107.

Their requirement to offer a choice of plans, or a choice of doctors, is not referenced in the legislation. We hear a great deal about the importance of choice of doctors. The Mitchell bill has it; the Dole bill does not. The Senate wants it, more importantly, the American people want it.

Elimination of preexisting conditions. The Mitchell bill phases out any exclusions for individuals that have preexisting conditions in a very determined, conscientious way. I daresay that under the Dole provisions, in the areas I have referenced, that element is still retained. The American people want to have it eliminated.

We have heard, Mr. President, a good deal about the issue of affordability and the issue of taxes. Under the Mitchell bill, it allows a maximum of 1.5 percent surcharge or marketing fee for plans sold through co-ops. On page 85 of the Dole bill—and this is just beyond belief, Mr. President. I hope I have the attention of the Members and the American people—"Administrative Charges: in general, in accordance with the reform standards, a community-rated health plan"—that is what we are basically talking about, community-rated, social insurance. We talked about that with the Republicans. Senator CHAFEE talked about the importance of community rating. And we have provided it in different ways in the bills before the Senate.

Listen to this under the Dole bill:

Administrative charges: In general, in accordance with the reform standards, a community-rated health plan may add a separately stated administrative charge not to exceed 15 percent of the plan's premium.

And to the plan's premium; $900, it could go for. $900. That is not even a tax. That goes to the insurance companies.

Let me point it out again. In general, in accordance with the reform standards, a community-rated health plan may add a separately stated administrative charge not to exceed 15-percent of the plan's premiums which is based on identifiable differences in marketing and other legitimate administrative costs. And then it goes on, and toward the bottom of the paragraph, "or a broker." A 15-percent additional charge under the comparison between the Dole and Mitchell bills. That would be $900. You talk about taxes?

Mr. DASCHLE. Will the Senator yield for a moment on that question?

Mr. KENNEDY. Yes.

Mr. DASCHLE. Let me ask the Senator if it is not also true that the Dole plan allows a similar 15-percent administrative charge to be added to FEHBP

plans. In other words, any non-Federal employee who wanted to participate in the Federal Employees Health Benefits Program would also pay a 15-percent administrative charge; is that not also true?

Mr. KENNEDY. The Senator is exactly correct. That is over on page 117, section 9002, Applications to Small Business Participants.

On the top of that page it says, "A carrier offering a health benefits plan under this chapter may charge a fee to participating small businesses."

Have we not heard much about small businesses out here in the last 2 weeks, about the sensitivity to small businesses? Here, under this plan it says, "a carrier offering a health benefits plan under this chapter may charge a fee to participating small businesses." Right here, for the administrative expenses related to the enrollment of such businesses, and to Federal employees. Fifteen percent of the premiums charged each such business. That is another 15 percent, another $900.

We are talking about billions and billions of dollars here. It is wonderfully sanctimonious for those around here to talk about the Mitchell bill and the various provisions in here about comparing cigarette taxes when we spend over $21 billion a year in the health care system taking care of people that are using tobacco, and they are quoting about all those increases in taxes. Here, this tax isn't even a tax; it's $900 that goes right to the insurance company.

Let me just point out how they define this. So you have those two provisions in this measure. If you go to the issue of portability, as the Senator knows, under the Mitchell bill, access to the Federal Employees Health Benefits Program is for all individuals in what they call the community-rated pool, employees and firms under 500, nonworkers, the self-employed, 78 percent of all of the under-65 population.

So the great number of Americans will have access to the same coverage as we have—and we could talk about how we want to strengthen this and other proposals that came out of different committees. The Mitchell bill makes it available to effectively 80 percent of all Americans under 65.

We have talked on both sides of the aisle, and I have listened about the importance of making available to the American people what is available for us. I pay, with the family coverage, $101 per month. I would think most people would feel that is a very good deal. It is a good deal. We do not hear of many people around here talking about it. It is a good deal, the kind of deal we want to have for the American people.

We heard from the other side, so the Federal Employees Health Benefits Program is a good deal. Let us include it in our program. Look at the difference in the Dole bill on page 115. "Self-employed individuals and small-employer participants in the Federal Employees Health Benefits Program."

First of all, there is no mention of a choice of doctors in here whatsoever. But let us go on. "For the purposes of this chapter, the term 'small business' means any business entity which employs 50 or less employees, including businesses with self-employed individuals." And then it goes over the application to small-business participants on 116.

I would like to have my good friends from Nevada and Washington and Colorado listen to this description. "The Office of Personnel Management shall promulgate regulations to apply the provisions relating to health benefit plans, to the extent practical, to small businesses and individuals covered under the provisions of this chapter."

One would read that—any child would read it—as small businesses and individuals covered under this chapter.

Now, two paragraphs down, it says: "Notwithstanding the provisions of subsection (a)," which I have just read, "the provision shall not apply to individuals covered under this chapter, except the Office of Personnel Management shall establish a method to disseminate information relating to health benefit plans to such individuals through small-business participants and carriers."

In the one place they say it is going to be small businesses and individuals, and in the next paragraph they take it away, as the language does, from any individuals. Individuals can participate, but the only way you are described as an individual is if you are going to qualify for coverage from the small business participants.

Then it says: "The carrier offering the health benefits plan under the chapter may charge a fee to participating small businesses." That is what we talked about before. Basically, in one paragraph they talk about small businesses and individuals, and two paragraphs later they say that notwithstanding that paragraph, the coverage shall not apply to individuals.

So this is why, Mr. President, it is important that we consider exactly what is in this legislation.

Finally, I will just mention the issue of portability. This is enormously important so that families know if they move from one job to another, they are going to continue their coverage. Every worker that enters the job market today will have, unlike 35 or 40 years ago, seven different jobs.

Forty or fifty years ago if your father was a shipfitter or ironworker in the Quincy shipyards in Massachusetts, your father or grandfather had that job for life, and they made good money, so that their wives generally stayed at home. Of course, society and market forces have changed things a lot. Women are in the job market because they want to be, should be, and they need to be.

We found that in the change in our economy everyone who enters the job market is going to have seven different jobs. We are trying to have the portability.

Under the Mitchell proposal, you have a similar kind of a benefit package whether you live in Salem, MA, or Salem, OR.

So you move through the whole process. It may be a different company, but it is the same package.

But it is not within the Dole proposal. It is not within there. There is no requirement that your employer pay for the standard package. But, you are still going to find that individuals are going to be wanting to move. So the idea that you can say, well, it is somehow portable, is false. This program just does not meet the most minimal standards in terms of portability. If you change jobs and your employer does not pay for coverage or offer you a plan, you are out of luck. If you lose your job, you could be out of luck.

These are the essential elements that I think are just worthwhile reviewing very quickly. Under the Dole proposal we are permitting the insurance companies to charge a 15-percent tax. The Mitchell proposal is 1.5 percent. This is a 15-percent tax. The FEHB plan is still closed to most Americans. Under Mitchell it is open to 80 percent of all Americans under 65. Under the Dole proposal it is a fraction of that.

There are loopholes allowing insurance companies to limit portability of coverage. If you do not have a similar kind of a benefit package and access to the same doctors and plans in different companies, then the idea that if you move from one job to the other that you are going to have coverage defies rational explanation.

You have no elimination on the preexisting condition exclusions, as I talked about in the Dole bill. Under the majority leader's proposal, all the preexisting conditions for the initial phase, the initial enrollment, are phased out so that they are eliminated by the year 2000. That is still there in the Dole program. Under the Dole proposal, there is no mention, none in the 600 pages of the Dole bill, about guaranteeing access to your doctor. In every reference to the benefit package under the Mitchell bill it talks about the fee for service, which is the option with unlimited choice of your doctor.

It talks about the loopholes that allow the insurance companies to continue the cherry picking. The idea is the companies themselves will not be required to pick up or insure individuals or individual groups. There is the flexibility that will be available to the insurance companies to continue to select the healthiest individuals out

there without responsibility in terms of coverage of anyone else.

(Mr. CAMPBELL assumed the chair.)

Mr. KENNEDY. Mr. President, I daresay that these are items which we ought to try and find some common ground—hopefully, we will later on in the day—in terms of the issues on children.

But it does seem to me that we ought to be able if we are serious, and the whole debate for the last several years has been about universality and whether we were going to be able to pay for it.

We were talking about preventive health care measures, and that is the issue that we will be addressing later on with regards to children. We have not even gotten into the very extensive programs in terms of prevention that are available in the Mitchell bill.

But we cannot tolerate any measure in this body that is going to continue to permit preexisting conditions and say to the 49 million disabled people in this country that we have passed legislation that has not attended to your needs. It will not be so. We have to say, if we are serious about the choice of a doctor or plan, we have to see it in the bill. We see it in the Mitchell bill, and we continue to ask where, where, where is it in the Dole proposal.

We have to make sure that the insurance companies' 15 percent tax—I read it in the RECORD the exact language that is included in the Dole proposal—that goes not to the Federal Government but goes to the private insurance companies at their will and they would be able to have that. The exclusion——

Mr. HATCH. Mr. President, will the Senator yield?

Mr. KENNEDY. I will wind up in 2 minutes. Then I will be glad to yield.

There is the closing down really effectively of the Federal employees program to people outside the Government and the limitation on the portability. These are essential elements, Mr. President, and I have heard our colleagues talk about them as being desired. I think it is important at this stage of the debate as we are moving toward hopefully a resolution of the children's preventive programs to say that we are going to try and see if we cannot at the successful conclusion of this debate and hopefully the passage of the children's amendment, address those issues.

I am glad to yield for a question, and then I do not intend to hold the floor any more. I see the Senator from Wyoming on the floor.

Mr. HATCH. Mr. President, I ask my colleague a question because he worked very hard on this issue and I know he feels very deeply about it. Is it not true that under the Mitchell plan, other than for the purchasing cooperatives, there is an open-ended marketing fee that can be charged; there are literally no limits on how much they can charge under the Mitchell plan?

Mr. KENNEDY. Will the Senator clarify this?

Mr. HATCH. Let me read it to the Senator. This is on page 51 of the bill:

> Marketing fees. No. 1, plans offered outside purchasing cooperatives, the community-rated standard health plan may impose a market fee surcharge for community-rated individuals enrolling in a plan through agent, broker, or other otherwise sales method or direct enrollment process. Such surcharge shall be in addition to the weighted average of marketing fees for such plans for community-rated individuals enrolled in such a plan for any purchasing cooperative in the community-rating area.

I think the Mitchell plan limits the market fee to about 1½ percentage points in the case of purchasing cooperatives, but for plans outside the cooperative, it is a completely open-ended fee, which is ridiculous.

The Senator is criticizing the Dole plan. At least Senator DOLE limits whatever the market fee can be. Let me tell the Senator that if the market fee is too high, I guarantee you that insurance is not going to be sold or bought.

Mr. KENNEDY. That is the whole point. Under the Mitchell bill, they do not have to pay that because they can remain within the particular program. They do not have to pay that. What the Senator is saying is in order for the plan to be competitive, it can't tax the people and the plan itself it has to pay it. The Senator is making my point for me.

Mr. HATCH. No, I am not.

Mr. KENNEDY. Yes, the Senator is. He is saying under the Dole proposal anyone who goes on into a plan, into the co-op, is at the will of the insurance companies to be charged up to 15 percent extra for an additional fee to be paid to the insurance company. Whereas, we are saying that if you want to pay a tax to the insurance companies or brokers, you can or you can go to the co-ops where people do not have those additional kind of fees. So nobody has to pay the tax because every plan has to offer through the co-op and every individual can buy through the co-op.

Mr. HATCH. If I could ask one other question?

Mr. KENNEDY. I yield briefly.

Mr. HATCH. What the Senator is saying is that there is only going to be one plan that the HIPC, the health insurance purchasing cooperative, can offer, because nobody else is going to be able to compete. If they stay in that plan there will not be any marketing charge. But I have to tell the Senator I think the free market system will compete. They are going to compete well, and they are going to have to compete. This is a false issue at best.

Mr. KENNEDY. I do not know why you give that kind of flexibility to the broker. You have the language here that the 15 percent administrative cost can go to the broker. How is that serving the American people to say you can tack on another 15 percent on top of that premium to go to the broker? What we are trying to do is to squeeze out the inefficiencies and the costs of the health care system at the present time. The Senator is writing that inefficiencies right into it.

Mr. DASCHLE. Mr. President, will the Senator yield?

Mr. KENNEDY. Yes.

Mr. DASCHLE. The Senator is absolutely right.

To clarify this point, is it not true that under the Mitchell plan every person has access to a purchasing cooperative, similar to what we have as Members of Congress through the FEHBP? Is that not accurate?

Mr. HATCH. That is certainly accurate. Of course, it is accurate. So you start with that premise that everybody has the same opportunity for access to the purchasing cooperative that we have. It is only things they are going to choose.

Mr. DASCHLE. The Mitchell bill guarantees that every single individual has access to a purchasing cooperative, which will make available to consumers many plans. One co-op may have 40 different plans. That is where the competition that we all say we want comes from. Is it not the case that, under the Mitchell plan, only if you choose not to participate in a cooperative that you could be subject to the 15 percent or higher tax that the Dole plan virtually guarantees? Is that correct?

Mr. REID. Mr. President, who has the floor?

The PRESIDING OFFICER. The Senator from Massachusetts has the floor.

Mr. KENNEDY. I yield for the answer.

Mr. HATCH. Basically, you are saying there is only going to be one way or one plan you can accept because you are not allowing insurance agents their ability to sell insurance. Let me tell you something. Unless they are competitive, they are not going to be able to do it.

But this business of the Mitchell plan saying that we are going to have a purchasing cooperative, we are going to allow them to sell insurance, we are going to allow free choice, we are going to allow a fee-for-service program, all that is rhetoric and words. You are going to force everyone into a purchasing cooperative run by the Government. That is the point I am making here.

Mr. KENNEDY. Mr. President, I will just say that we do have the competition within the co-op. The point you cannot get away from is the limitation under the Mitchell bill.

> In no event may the sum of the membership fee and the marketing fee charged by a purchasing cooperative with respect to a certified standard health plan exceed 1.5 percent * * *.

The Dole bill is 15 percent to a broker. This is 1.5 percent.

And you can cut it whatever way you want—but there's still an additional 15 percent to get the Federal employees program. Under the Mitchell bill, any business or any individual can join the Federal employees program.

I hope we will not be talking a great deal about additional taxes until we come to the explanation. That is $90 under the Mitchell bill versus $900 under the Dole bill. And that is not an insignificant amount.

Mr. HATCH. Could I ask one other question of the distinguished Senator?

Mr. KENNEDY. Sure.

Mr. HATCH. Do people pay the same premium under this program as they would for the Federal employees insurance?

Mr. KENNEDY. Yes.

Mr. HATCH. Actually, they do not for 6 years; am I wrong in that?

Mr. KENNEDY. Are you talking about the age adjustment provision?

Mr. HATCH. No.

Mr. KENNEDY. By the end of the phase-in.

Mr. HATCH. So you are talking about a 6-year phase-in before they can get the benefits of Federal employees program?

Mr. KENNEDY. That is exactly correct in terms of the premium payments, but the benefits are the same from day one.

Mr. HATCH addressed the Chair.

The PRESIDING OFFICER. Does the Senator yield the floor?

Mr. KENNEDY. Yes. Whatever time is going to be allocated on the other side. I saw the Senator from Wyoming earlier and I indicated to him I would not take long.

Mr. HATCH. I yield whatever time the distinguished Senator from Wyoming needs.

The PRESIDING OFFICER. Senators are not operating under a time agreement.

Does the Senator from Wyoming seek recognition?

Mr. WALLOP. Yes.

The PRESIDING OFFICER. The Senator from Wyoming is recognized.

Mr. WALLOP. Mr. President, it is a curious thing indeed what is happening here. The first thing that is happening is that rather than defend the Clinton-Mitchell bill, the other side of the aisle is attacking the Dole bill. And the curious thing about that is, the Dole bill cannot be before us under the rules that the Senator from Tennessee and the Senator from Maine have established.

We do not yet have a Congressional Budget Office scoring of the bill. The House wisely has gone home until they do have a CBO score. But the Senate excludes having a score, and therefore there is no way we can talk about this bill.

I would also like to comment on the Senator from Massachussetts' claims. Only in the Senate of the United States is an option allowed to an insurance company called a tax. That is not a tax. It is an option. It is not mandatory. It is an option.

But what is mandatory, make no mistake about it, is that if the Secretary of Health and Human Services does not like the plan of a State, she imposes a 15-percent tax that goes not to the broker but to the Government of the United States. Therein lies the big difference.

But we are still in an irrelevant conversation, because, the way in which the majority leader has structured this debate, the Dole bill cannot come before us, because we have been denied, first, printing and then CBO scoring. So this is an exercise in parliamentary dominance by one person, the majority leader, who has foisted upon the Senate no fewer than 4,300-and-some pages over the last week and who insists that we all ought to know what is in this when he, himself, has not been able to know what was in it, or surely they would have included all that they needed to include in the first version of the bill. But some things have been taken out and some things have been put in and nobody knows what all of those are, and I include the majority leader himself.

So, let us be fair with the thinking in front of the American people.

Over the past week, we have heard the First Lady, the majority leader, the President of the United States, and others reproach the Republicans for not wanting to debate health care reform. Now we are being reproached for wanting to debate the health care reform. Now we are being reproached for not agreeing to the majority leader's request to begin voting on his timetable for amendments. We are called obstructionists. We are told we are undemocratic. We are told we do not care about the American people. We are told that the only thing we care about is politics but that the President's agenda is not political.

Mr. President, anybody watching American politics knows that the President's agenda is no less political than the agenda of everybody else. He is, after all, the leader of his party and he has chosen to make health care reform a political and nonbipartisan effort from the beginning.

Members on the other side of the aisle are being asked to vote out any health care bill to save and conserve the Presidency. The Democratic leadership wants to pass the bill before the November elections, and it does not really matter what the bill says or what it will do to the American people. The Senator from West Virginia, I think, explained it the best when, in an interview, he said, "The American people are going to have health care reform whether they want it or not."

Now all of these accusations are offensive to us in elected office who listen to our constituents and are here to represent their views and seek to do so even if those views do not happen to comport with those of the Senator from Maine or President Clinton.

The debate on health care reform is a philosophical debate. It is a debate which clearly delineates the differences between Republicans and Democrats over the role of Government in our individual lives. Republicans are unwilling to rush this debate, not because we do not want to have health care reform, as the Democrats cry, but because we are unwilling to vote for a health reform proposal that is philosophically opposed by our constituents.

Let me put, if I can, the issue of reform into some sort of perspective.

If I look back on nearly 18 years in the Senate, there are three defining moments in this period.

The first was in 1981, when the Senate approved the Reagan economic revolution, a program which included reductions in Federal income taxes, reductions in domestic spending, and increases in our national defense budget.

The second was the defeat of socialism, graphically illustrated by the fall of the Berlin Wall and the collapse of the former Soviet Union.

The third event is the current debate on national health policy.

All three are linked by a common thread. All are attempts to define and to limit or, in the case of the latter, to expand the role of central government planning in our lives.

Reaganomics was an attempt to let people keep the resources they created through their private initiative, rather than allowing the Federal Government to collect and expend these resources. By limiting tax revenues, it was hoped that we would limit the growth of Government, because taxes and taxes alone are the means by which the Government gains the power over the people of this country. We were frustrated by Democrats in Congress who insisted on expanding Federal spending through deficit financing.

The fall of communism was a repudiation by the people of Eastern Europe and of Russia of the failed ideology of centralized government planning; and the defeat of the philosophy was combined with the fiscal defeat of the centralized government when we faced a socialist regime in Baghdad during the gulf war.

And now we are being asked to approve, with minimal debate—and I say with minimal debate, notwithstanding the promises of the Senator from Maine, the majority leader, who, at the beginning, said no Senator would be curtailed and is now seeking to curtail us. But, most important, we are being given little time to analyze the most massive explosion of Government—maybe in this half century. The Clinton-Mitchell bill will transform one-seventh of our economy, by creating 50

new bureaucracies and at least six new open-ended Government spending programs; by creating new subsidized entitlement programs that will cost $1.4 trillion between the years 1995 and 2004—in that decade, $1.4 trillion.

It will increase Federal taxes by $300 billion over the next decade, paid for by 83 percent from middle-class Americans who will find themselves not only paying more taxes but higher premiums for their health insurance. It proposes almost $1 trillion in unrealistic cuts in Medicare and Medicaid.

These true costs do not vanish because we cut them. They go directly onto the backs of the rest of Americans who pay for health care. By cutting Medicare and Medicaid you just do not simply eliminate the fact that a procedure costs a certain amount of money. And if it is not paid for by the Government, then it is going to be paid for by the hospitals and doctors who perform them, and who ultimately transfer those costs onto the backs of the premium payers, insurance companies, and individual Americans seeking health care. It goes to the middle class; it goes to small business.

The health care proposal now in front of us represents a reversal of recent successes against Government centralized planning and control. There are some in Congress who believe that any issue arising in the country must be resolved by creating a new Federal program. There are some in America who, every time confronted with discomfort, say, "Why does the Government not do something?" There are others of us, however, in America, who believe that solutions cannot only flow from Washington; that neither the private sector nor the State government have the ability to solve problems because it is controlled by the Federal Government, and we have witnessed how successful the Federal Government is at the rest of its efforts.

There are, unfortunately, those in Congress who subscribe to a "big nanny" philosophy, and they are the same people who have drafted the health care plan now being debated. "That we Americans have not the ability wisely to choose what is good for our families, what is good for our employees, what is good for our country. We must have this group here in this Senate and in those bureaucracies doing it for us because we are not to be trusted. Only inside the Beltway resides wisdom"—so those people would think.

The health care reform debate is a true turning point in this country. That is why it is important to analyze it fully and accurately. And there is no going back. We step off this ledge into Government controlled health care and there is no turning back.

We have only to look at the amendment that is now before us to accurately predict what is going to happen. Once you get a standard benefit package there is no end to the bidding—no end to the bidding. There is always somebody who is going to want something in that standard benefit package. Ask those in Hawaii who now find their health insurance program too expensive for the State to support. Because year after year, session after session, everybody politically bids up what is contained in that package.

The fundamental issue, therefore, that we must decide, is whether we believe in a bigger Government, or in a wiser and more empowered people; whether we will be ruled by an anonymous bureaucracy which has the power to levy taxes or assign them, which has the power to limit choice—or whether democracy will continue to be our form of Government.

Those who believe the Federal Government is the solution of our health care problems will vigorously embrace the Clinton-Mitchell bill. Those who believe, as do I, that our health care problems can be solved better by relying on the common sense and abilities of the people, are the people who will support the Dole-Packwood health care alternative, or some involvement which solves the basic problems which face Americans—that of access, portability, preexisting condition, and the issue of malpractice and simplicity.

Government slowly, slowly, slowly has been overtaking our lives. In one generation, Government has doubled the amount of money that it takes from Americans and it has increasingly used that money to deprive us of control over our own lives. In the same time it has turned our public spaces over to criminals and our public schools into factories—yes, of ignorance. Government has driven us apart on the basis of race, and even of sex, and in the name of tolerance has made us almost the most intolerant country in the world.

Throughout the world, big government is in the crisis of legitimacy. In South America there is a rush to privatize Social Security and Medicare, to privatize the State corporate structure. The Japanese, recognizing that their industrial policy has bred corruption as well as inefficiency, are deregulating their economy. Europe's welfare States, that spend more than half of their GNP, are collapsing and dragging the mainstream parties down along with them. Look, for example, at Germany and its health care plan which is, in effect, the Godfather of the Clinton plan. And in fact, the First Lady is the one who has said that she would like us to look more like Europe.

According to remarks in a Wall Street Journal article by Wilfried Prewo, Chief Executive of the Hanover Chamber of Commerce in Germany, the German plan provides near universal coverage but at great losses of efficiency. The average premium payroll tax is 13.4 percent, paid for by every working individual. The German alliances, originally devised as nongovernmental health purchasing cooperatives, have degenerated into de facto government agencies with 112,000 employees working for these alliances.

The administrative cost of the cooperatives have risen 53.5 percent from the last decades—more than the measure of the alliances total health costs. As Prewo notes, "These costs reveal that the disease of bureaucracy is the real problem". Hidden taxes are also an integral part of the German plan. A 50-percent employer mandate results in labor costs that make Germany the second most expensive place to employ people in the world. It is also a country that has significantly higher unemployment rates than does the United States.

Financially, the German plan has vacillated between financial distress and collapse, and the Government has intruded with ever tighter regulations, including price controls and access rationing. The German health care costs are rising rapidly and Germany has taken some stopgap measures to control them. But major health care reform will be undertaken in the coming years. They have no choice. Germany is searching for a way out, to have less Government control and to establish some market orientation. Incidentally, many people are now going to the Eastern European States for their dental care because it is cheaper and you can get it right away, without waiting in line.

So, why is it, as other governments in the world move away from socialization and toward market-based programs, our Government is trying desperately to move toward it?

Let us talk for a moment about the issue of choice. For years, health reform has centered on the question of how health care can be provided efficiently and effectively. But there has always been something missing in this debate, which has doomed efforts at cost restraint and access. That is that we have focused so dogmatically on how we can expand access to care while controlling costs, that we forgot the critical element in a free market-based economy—choice. We have not had it.

If the market is to work, individuals must have the ability to choose, to make decisions, to accept responsibility—a key word in a democracy, Mr. President: Responsibility—accept responsibility for their health care.

Some would argue that responsibility and choice are unnecessary, that the Federal Government will assume all responsibility and make our choices for us. That will never work with the American people.

It may be what is imposed upon us, but because it is imposed, does not mean that it works. It is the focus of the Clinton-Mitchell bill. Government

under that bill would assume responsibility for defining the standardized health package that we will have, for telling us how we must purchase it through mandatory HIPC's, or by forcing employers with less than 500 workers to buy at community rates instead of self-insuring, or by making experienced rate plans contribute to a risk adjustment pool supporting alliance.

Incidentally, this is where the President of the United States is absolutely wrong in his statement that we will have choice. You cannot have choice if you are to be fined for exercising it. You cannot have choice if your employer is to face a $10,000 per employee fine for offering either less or more. You cannot have choice by telling us that we must purchase insurance through an individual mandate, for telling businesses that they must provide insurance for us.

The Clinton-Mitchell bill contains at least 23 new mandates on employers, employees, individuals, and States. Public policy over the past 25 years has been driven by the demands called entitlements. We have established by the President of the United States an entitlement commission whose job is to seek ways to find relief for the American taxpayer, economy, and Government from the dictates of entitlements.

Incidentally, these are figments of Government fantasy, not the Constitution. Nowhere in the Constitution does it say that any American is entitled to the earnings of any other American. These are things we have done to ourselves. Yet, in this program, we are establishing a number of new entitlements.

People have been permitted to engage in whatever activity they choose without assuming responsibility for it under the health care system that exists in this country. Indeed, they have come to expect from the State and the Federal Government the performance of functions traditionally reserved for heads of households. The expanding entitlement society is destroying the sense of personal responsibility and of collective responsibility and of community responsibility. After all, if the Government is going to do it, why should I be charitable? If the Government is going to do it, why should I seek any other resolution? And why should I care who exercises the choice to be entitled to the money that I and my fellow citizens earn?

The expanding entitlement society has destroyed this sense of personal and collective responsibility, and there is no more evidence than in the area of health care. Under the Clinton-Mitchell bill, the individual is now entitled to standard benefits provided by the Government through new mandates on the society. The expectation exists that there is a right to health care. The President has stated it; advertisements have stated it. But there is no such right—there may be an obligation, there may be a sense of that obligation—but nowhere in the Constitution does it say that the Government of the United States must provide every American, no matter what that American does, with all he wishes in terms of health care.

Under Clinton-Mitchell, there are attempts to provide coverage to the 23 million uninsured by providing subsidies to benefit 100 million. How does that work, Mr. President? Twenty-three million are uninsured; subsidies for 100 million. Whose pocket is robbed to pay that? I guarantee you that many of those who are going to be subsidized will be having the other hand in their pocket taking it right back out on the other side.

The costs of these subsidies will be borne by those unlikely enough not to receive a subsidy, mainly the upper portions of the middle class. It is time, therefore, to restore the idea of responsibility to the health care debate. Responsibility means making decisions. For instance, each of us decides whether or not to maintain a healthy lifestyle, to exercise, to refrain from smoking, to drink moderately; or the opposite.

As a recent article in the New England Journal of Medicine indicates, such decisions to accept greater responsibility for what the authors call "demand reduction" would reduce annual health care expenditures by almost 20 percent. That means $180 billion.

Mr. President, the Government of the United States cannot have lifestyle police. It cannot. It cannot have somebody watching each of us in the closets and in our rooms to see if we sneak a cigarette or drink an extra martini or do not get enough sleep or eat too few carrots. They cannot do that to us. So by imposing all of this bureaucratic regime on top of us, competition and choice is eliminated—something which is available in the private insurance marketplace.

Another decision which most people cannot now make and which is a problem, and that has been cited by those on the other side as well as on this side, is that most people cannot choose the health insurance plans they are provided by their employer, or by their States. They can choose not to have the one by their employer. In fact, I, indeed, could choose not to have one by my employer and have one by my wife, who is self-employed and provides it for her employees.

But most Americans receive health insurance coverage through their employer, and the employer chooses that plan. But the employee has no choice on the benefits of which the insurer will provide. There is no choice; therefore, there is no responsibility, and little cost for the employee. But there is also no option. If a benefit is covered, use it; if it is not covered, forget it, I am not going to do it because nobody is going to pay for it.

No wonder individuals feel they have a right to health care, an assertion which ultimately turns free-market economics upside down. And the lack of choice is only exacerbated by the Clinton-Mitchell bill which has Government mandating the purchase of plans and defining the benefits included in those plans and not allowing us the options of choice as employers or employees—low-cost plans, high-benefit plans, one is taxed, the other is disallowed.

If the Government takes responsibility for all of these, how are we to expect individuals to exercise it on their own?

What must be understood in this so-called right, this false notion of security, is that it comes with a price: A price in freedom and a price in coverage. In exchange, individuals on a Clinton-Mitchell regime will be given reduced coverage, increased premium costs, and increased taxes—I will examine that now—but more importantly, freedom and liberty will be lost through the imposition of 50 new bureaucratic regimes that will impose so many rules and regulations that bureaucrats, not individuals, will tighten the existing controls that they have over our lives. And who knows where these people derive their power, or who they are when they exercise it?

There are a number of aspects in the Clinton-Mitchell bill which reduce coverage. A new high-cost premium tax I mentioned that CBO says, and let me quote—incidentally, CBO was not kind to the Clinton-Mitchell bill. It basically said that it would achieve some goals and it was revenue neutral, but thereafter, it slammed it in almost every corner it could find. Let me give you the first of those.

The new high-cost premium tax would be difficult to implement. Its contribution to containing health care costs would be limited and it might be considered inequitable and an impediment to expanding coverage.

Some health care reform: Inequitable and an impediment to expanding coverage and difficult to implement.

New Federal and State premium taxes will add 17 to 42 percent to the cost of buying a health plan.

Some cost containment.

Standardized benefit packages would make illegal many cost-effective products now on the marketplace.

Small employers, those with fewer than 25 employees, who currently offer health insurance, would not be willing to offer more than 50 percent of the cost of the insurance because, otherwise, the employees become ineligible for the subsidies. What kind of a crazy thing is the Government going to do when it actually says that it wants employers to do these things—and many of them are, and those are the people

they cite—and then turn right smackdab around and say, "If you give them more than 50 percent, the Government will not subsidize." No rational employer is going to give more than 50 percent.

Another thing. In order to achieve this massive coverage by the Federal Government health care plan, we have the possibility of a State-by-State mandate. The distinguished President occupying the chair is from the State of Colorado. They might well make the Government requirement for coverage. There is no way that it can happen in the State of Wyoming or any other rural State. And those in my State go under a mandate and perhaps those in the State of Colorado do not, or perhaps both of our States and the States of Kansas and Nebraska do not. Our employers are going to be shopping the area to find the cheapest place to employ people. But what does that do to the economy of the United States when the Government by exercising a willy-nilly mandate begins to put inequitable positions on the employers in our several States?

Mr. President, there is this magnificent assumption somehow in the minds of socialists that society is ultimately perfectible and that we are all essentially sheep and we have no human responses to its efforts.

If firms with 25 employees or less are not to be covered, who will be so unwise as to hire the 26th employee? How does that add to jobs in America? If your penalty begins with the 26th employee, the best thing you can do is start another company, if you want more employees. People will respond to the artificial stimuli that are contained in this ridiculous piece of legislation because the Government is interfering, choosing amongst winners and losers, States, individuals, employers and all kinds of things. It chooses, chooses, chooses, and it assumes that none of us are wise enough to have a human reaction to the opportunities that are put in place by those choices.

We constantly hear that the Clinton-Mitchell plan is necessary to help the middle class. But under that plan direct new taxes and hidden taxes, still taxes, if you will, on premiums will both shift and increase the cost of health insurance onto the backs of the middle class.

There are at least 17 new taxes, some have said 18—and I believe that 18th to be the most insidious of them all—in the Clinton-Mitchell bill. They raise $300 billion. The one new tax that is not listed on here is that if the Federal Government does not choose to accept your health plan, it imposes its own and then charges a 15-percent premium on every insurance policy sold within that State. That is not the Congress levying that tax. That is the Secretary of Health and Human Services.

There are many other hidden taxes and State taxes that will add to the premium costs and increase these middle-class taxes. Two-thirds of the new Federal taxes, $200 billion, fall squarely on the shoulders of 83 percent of all Americans through higher costs on health insurance premiums. Two-thirds of it goes right on health insurance premiums that people now pay. The 25 percent high-cost plan costs $70.4 billion.

In other words, if your employer seeks to provide more health insurance than a target premium cost, you get a 25-percent tax on that premium. A 1.75-percent premium tax raises $74.3 billion, and the repeal of cafeteria plans and flexible spending accounts costs $46.8 billion. These are things that Americans now have for which they will be taxed.

Let us talk about them. The high cost premium tax, $70.4 billion. A 25-percent excise tax is applied to community-rated and experience-rated health plans that exceed a certain target cost. This is touted as cost containment, Mr. President. This tax, according to CBO, will do little or nothing to contain health care costs and might impose an impediment to coverage. Some kind of cost containment. Virtually all plans would be subject to the 25-percent tax. This tax is really a sick tax. You can use that in either way. It is a sick tax or a sick tax.

Perhaps someone from the other side of the aisle might in their time explain it differently. But it appears to this Senator that some of the plans which will pay the highest taxes are those that have an inordinately high number of sick and older individuals. These are the plans that by definition have to raise their prices the most to cover the high levels of provider reimbursements.

In other words, you are going to have certain levels. They have a certain inequitable portion of either the aged or the unwell, and they have to raise their premiums to cover that, or cease to provide it altogether. And guess who gets to pay it? The sick and the aged and the unwell. I understand that there is a risk adjustment mechanism to compensate plans that have adverse health selection, but it is my understanding that no such risk adjustment mechanism currently exists.

The American Academy of Actuaries, when analyzing the President's original risk adjustment mechanism, which may be actually less complicated than that of the Senator from Maine, stated:

> Such mechanisms can never be expected to be fully effective. Further, the current state of the art in risk adjustment falls short of meeting the requirements of the act.

So if risk adjustment does not work, Mr. President, then this tax clearly penalizes the elderly and the ill. But that is not all. The tax applies to community-rated plans in 1997 but will apply to large self-insured employers following in 2000. Most small businesses purchase insurance in the community-rated market.

I ask the supporters of the Clinton-Mitchell bill, why should small businesses have to pay the tax now when big businesses will not have to pay for another 3 years? Is this fair to the small business employers of America? Is this not a subsidy to big business by a Democratic administration claiming to be on the side of the little people in America? And since there are no constraints on large employers for 3 years and the premiums for those employers are based on their health expenditures during that period, you have to ask the question, will not this seriously undermine the incentives for these plans to economize before the year 2000, as CBO suggests?

In fact, the incentive does quite the opposite. Insurers have the right to collect 50 percent of the cost from providers as long as the amount does not exceed the provider's disproportionate share. That is a very interesting little complication in life right there. Maybe someone will be able to explain to me and the Senate how an insurer is going to go about collecting these fees. How is it possible, Mr. President, to recover 50 percent of the tax in a timely and efficient manner when the provider's proportionate shares are based upon factors not known until the time beyond the end of the next tax year? How is that going to be?

What we have done is not only provided an unfair tax, a monstrously complicated tax, but somebody is going to be fined for not complying with it when it is impossible yet to achieve compliance.

And then, Mr. President, why should the low-cost provider have to reimburse the plan's sponsor for 50 percent of the tax imposed because of the excess charges of high-cost providers?

So what you have done is you have simply said to everybody, go for the gold. Make it as rich and expensive and as nasty as you can because if you are a low-cost provider you are going to be subsidizing the high-cost providers and nobody is going to be able to figure out how to collect the tax.

How much additional administrative expense do you think will result from this giddy collection exercise? Even CBO stated that this tax will result in litigation expenses. And is it even appropriate for health plans to play tax collector when you are trying somehow or another to make the system more efficient, to bring the costs down? You are adding administrative and legal costs. There is no end to the complication and to the furor that this plan and this tax will impose on our society.

The fee-for-service plans, which allow unlimited choice of providers, are generally more expensive than network-based plans and this tax will make the fee-for-service plans even more expensive and potentially unaffordable all at

the same time the President and Senator MITCHELL promise us we are going to have choice. So the fee-for-service plans under which you have choices are going to be driven up because the taxes are higher and potentially unavoidable. It simply denies consumer choice of providers. Overall, this high-cost plan tax will tax cost efficient plans more than inefficient plans. A funny thing in a country that seeks expertise. The worse you are, the less you pay and the better you are, the more you pay.

Mr. President, does the Senate really want to go down that road? Is that really what we are up to?

The sponsors of the tax claim that its purpose is to reduce health costs. But it is hard to see how raising premiums makes health insurance more affordable when talking about the 1.75 percent tax on every health plan to provide for more teaching hospitals. This tax is applied to all gross premiums. So straight across the board, everybody's health care costs in America goes up 1.75 percent. It raises $74.3 billion out of purchasers of health insurance over the decade, and falls directly on the middle class.

The Joint Tax Committee has prepared a distributional chart which shows this tax clearly falls more heavily on the middle class. In 1999, 54 percent of the tax increase will be paid by people with incomes of $50,000 or less and 79% by people with incomes $75,999 or less. The 1¾ percent tax will increase the taxes of individuals with incomes between $20,000 and $30,000 by $1,178; between $30,000 and $40,000, by $1,303; between $40,000 and $50,000, by $1,099; between $50,000 and $70,000, by $1,955, nearly $2,000. Some savings, Mr. President.

This new tax is not in any way related to making health insurance available to the uninsured. In fact, what it serves to do is further increase the premiums of the already insured. It has been linked to new spending for medical education. Yet, while it raises the costs of premiums for everyone by 1.75 percent, it more than doubles current funding for medical education.

Is the purpose of health care reform to tax Americans into doubling their contribution out of their own pockets to medical education, at the time as everybody is saying that we are producing too many doctors? It is bizarre, Mr. President.

It is my understanding that funds currently available under Medicare are transferred into new trust funds: The Academic Health Center Trust Fund and the Graduate Medical Trust Fund, and others.

These transfers total $71.1 billion over the next decade. But according to CBO, the tax raises almost $11 billion more than is claimed to be spent on these programs. So here is a nice, new little tax increase for Americans. Even if they support it going to medical education, it gives $11 billion more to Government; just to Government. It is not directed.

It is nothing more than a convenient revenue raiser that can be increased every time the Government runs out of money to meet its commitments, all while we are calling it "medical education." We will raise it another quarter percent. We are already $11 billion more than spent. What the heck, let us give you another $20 billion.

Mr. President, this is hiding real taxes from American people in a most irresponsible way.

So I find it extremely difficult to understand how the bill is supposed to cut costs when all it is doing is increasing the cost of private insurance. I had thought that the majority leader indicated that the plan was necessary to avoid premium increases. Yet inherent in the majority leader's plan are several provisions which drive premiums up.

Now we have a wonderful provision. Our States are allowed—the words used "are allowed" to raise their premium taxes by 1 percent to pay for new administrative expenses which they are not allowed to avoid.

Where is this Congress coming from that it says that our States are allowed to raise taxes to cover expenses that we impose upon them? What is wrong with the concept that the country was founded on the notion that these States are sovereign, and that we here in Congress derive our power from the States, not the States from the Congress? What a bizarre distortion of American political philosophy.

The Clinton-Mitchell bill allows them to cover the costs of administering, and nobody believes that what they will be allowed to do will be enough. So the States are going to raise premiums another 1 percent. But we will not be blamed for that. Clinton-Mitchell will not be blamed for that. The States will be blamed for paying for things that we are requiring them to do.

First, the Clinton-Mitchell health proposal would be forced on the States. As CBO states in their report, "[it] would place significant responsibilities on States for developing and implementing the new system." Then we tell them to raise taxes to pay for the cost of administering their new duties which we, who derive our power from them, are imposing upon them.

The States, Mr. President, will have 177 new responsibilities under this plan, including determining eligibility for the new subsidies and continuing their Medicare program. Administering the subsidy and the Medicaid programs, establishing the infrastructure for the effective functioning of health care markets, and regulating and monitoring the health insurance industry. According to the CBO report—again this very thin praise which accompanies the Mitchell bill—"it is doubtful that all States would be ready to assume their new responsibility in the time frame envisioned in the proposal."

So what happens, if they are not ready to assume their responsibilities? Guess what? The Secretary of Health and Human Services assumes those duties for them, and imposes a 15-percent tax on all the premiums. That is a 15-percent tax that goes on every health plan premium in the State where the Federal Government takes over. CBO says the States will have difficulty meeting their responsibilities, and yet we blithely go along, and say, "What the heck. They cannot do it. That is 15 percent more for the Federal Government. We will do it for them. We will run their plan and impose a tax on them." Goodbye States rights. Hello Washington.

If Secretary Shalala determines that a State health system does not meet requirements from her view of the insurance coverage, then she takes over the State system. If she takes them over and runs the plan, she increases the premiums by 15 percent to pay for the administrative expenses of the Secretary. The complaint the Senator from Massachusetts was making a little while ago is that the insurance companies might be allowed to impose a fee. That is a big difference. One is an option, and the other is a tax imposed by a nonelected, but appointed, bureaucrat.

Now we have the disallowance of current tax-free health care expenditures made through cafeteria plans and flexible spending accounts; another $47 billion out of the pockets of Americans who buy insurance. A few more billion out of cafeteria plans—plans that allow individual Americans to make the choice of the coverage they wish to have.

Mr. President, I have stated before that it is conceivable that my wife and I at this stage in our lives will not need obstetric care. It is even more conceivable that the care that I might want would be hair transplants and hearing aids. Should I not have the choice to have that instead of the obstetric care which we no longer will have use for? Not according to Clinton-Mitchell. Cafeteria plans are out. It is a sin to provide yourself and your family what you believe to be necessary to their well-being.

Flexible spending accounts, whereby some insured have a high-cost deductible, figuring that they can take care of the first $1,000 or $2,000 of their medical expenses, in exchange for a really good catastrophic plan. Oh, no. That will not be allowed. You are penalized $10,000 an employee if you provide your employees more than the Government says that you are entitled to have.

This is a fine Government that comes along and says to employees, and families, "I don't care if you want it."

(Mr. BYRD assumed the Chair.)

Mr. WALLOP. You may not have it without extraordinary, new penalties. Clinton-Mitchell eliminates those options and again increases the out-of-pocket costs of middle-class Americans, and eliminates their choice and their right.

Now, the risk adjustment. An egregious hidden tax is this adjustment which requires all employers with over 500 employees to participate in a risk adjustment pool with individuals and small employers in each State. The risk adjustment provision forces self-insured employers, who may have lowered their own costs, to pay higher insurance rates to subsidize the higher risk of other employers.

Why, if we have done something well within a corporation of mine, should we be required to subsidize the risk of the employers of another corporation that does nothing to contain their health care costs and the risk of their employees? By shifting these costs, it is no different from a payroll tax increase. Once again, the healthier the plan, the more efficient the plan, the better you are—under the Mitchell-Clinton bill—the more expensive it will be. Those who are good and efficient now had better see to it to get bad and inefficient. It certaily is in your own best interest, because it will be cheaper when it all rolls in.

The bottom line is that the middle class gets socked, and socked heavily, with the distributional impact of the four taxes in the Mitchell-Clinton plan—1.75-percent premium tax, increase in Medicare part B, disallowance of cafeteria and flexible spending accounts, the tobacco tax increase, offset by the 50-percent deduction for self-employed. Joint Tax found that 60 percent of all taxpayers with incomes of $50,000 or less will pay the higher taxes. Some 78 percent of taxpayers with incomes $75,000 or less will also pay the higher taxes. Incomes between $20,000 and $30,000 could pay $3,000 more a year. Between $30,000 and $40,000, you could pay $3,100. Between $40,000 and $50,000, $2,690. Between $50,000 and $75,000, $3,800. Those are big tax increases, Mr. President. And they do not reflect all of the tax increases mentioned above that will come from the States or the 25-percent premium taxes.

The Clinton-Mitchell plan does not stop at increasing premium taxes. It also includes a number of hidden taxes that will further increase the costs of health insurance. Companies with 500 or fewer employees are forced to purchase insurance through a community-rated pool. This means that smaller companies who may now self-insure, or may have efficient plans, will have to pay for insurance that will be significantly higher than they now pay and will not to be allowed to self-insure—that is too much independence from great Uncle Sam—will not to be allowed to do something on their own; will not to be allowed to be accountable and responsible and to work with their employees.

It increases costs on all the insured, everybody in America, by forcing them to cover more benefits for subsidized people than they receive from the subsidies. Guess what, Mr. President? Not only are these people from the healthier and more efficient plans being asked to subsidize other people, but the cost assessed them for that subsidy is more than the subsidies. So it is a cute, hidden little tax that is going on the middle class, and it is no small figure.

Under our current health care system, Medicare accounts for two-thirds of the cost shifting that occurs. Guess what? We are proposing to reduce Medicare again. Nobody does anything about the cost that Medicare incurs. Instead, the cost is just shifted onto the backs of those who are already healthy and employed.

The Clinton-Mitchell bill proposes to cut Medicare by $200 billion over 10 years, with all of the costs, or most of them, falling on the provider. Are the providers to shoulder that entire tax, or does anybody suppose they might portion it out to those to whom they provide? Look at the reality of this. Nobody is going to pick up $200 billion all onto themselves when they have the option of spreading it out. Guess who gets it when they do that? Middle-class America, employees and employers of the small and productive sector of this great country.

So instead of solving the cost shifting problem, as the majority leader is so quick to claim, his bill actually exacerbates the already existing problem.

A recent Wall Street Journal article by Martin Feldstein found that this will result in at least a $13 billion annual tax increase. But the cost-shifting problem does not stop there. Under the Clinton-Mitchell bill, Medicaid is cut $788 billion over 10 years. These two cuts total almost $1 trillion. Medicaid beneficiaries not receiving SSI or Medicare would be integrated into the Federal subsidy program. These recipients are placed in the community-rated pool with small businesses and individuals. Guess who shoulders that expense? By cutting Medicaid, it does not disappear as an obligation for somebody to pay it. That is the great boondoggle that is contained in this Mitchell-Clinton bill.

Incidentally, we have never been able to achieve the cuts claimed. My guess is that we will never see the day when we do. So, either way, it is going to be the Federal Government who is the biggest imposer of health care cost shifting, whether or not we pass this bill.

The Government would pay the subsidies for these beneficiaries, and if the subsidies do not meet the costs, guess what? The insurance companies and, therefore, everybody else they insure, will end up paying the difference. According to Feldstein, this cost shift could end up costing $29 billion a year.

Increased premium costs for younger workers. Perhaps one of the nastiest, most unfair, egregious hidden taxes of them all. As Robert Samuelson starkly stated in the Los Angeles Times on the 10th of August, it is a "multibillion dollar tax on younger workers." It occurs because of community rating, which requires everyone to pay the same rate of insurance regardless of age. Guess why AARP is so willing to support the Clinton-Mitchell bill? According to a recent Washington Post article, young adults under the age of 35 will pay at least $40 billion a year more to subsidize the middle aged, which translates onto the young workers as a 7-percent payroll tax increase—right smack dab out of the people just starting in life, wanting to buy a home or an automobile, or get married. A Neil Howe and Bill Strauss editorial in the Washington Post, called "A Hidden Tax on Young People," is the source of that information.

For example, a 27-year-old male who currently pays an average premium of $788 would find himself paying $1,485 under a pure community rating. That is an 88-percent increase. So I ask my colleagues, yes, we care about the aged and women and children; but do we care nothing about the young workers coming along and their hopes and dreams for houses and other things, along with the fact that they are inherently healthier than we are?

The administration, in its 1995 budget, declared that future generations could face taxes that are upward of 82 percent of income—82 percent of income—if spiraling health care costs and other entitlements are not brought under control. Yet the Clinton-Mitchell bill places the burden of health care reform squarely on the backs of future generations, without doing anything for cost containment. So what they have done is simply looked the other way and promised people something that cannot be provided.

We should not and cannot burden the future of America with today's health care costs. It is the job of this generation to leave to future generations a standard of living that was better than the one that was left to us. And we are dead set on denying people responsibility, choice, and most of all opportunity, by enacting this Clinton-Mitchell bill. We should not be squandering a standard, passing off costs we are too scared to face because they have political ramifications.

The American people are being deceived into believing that this Clinton-Mitchell bill will provide them security at no cost—security at no cost.

There is just a wonderful scam in the papers this morning, Mr. President,

about a bunch of people who bought wonderful travel opportunities at below costs, huge numbers of Americans seduced into buying something below costs. They got an extremely expensive lesson, but they did not get travel below costs.

That is what we are about in this process right here. We are about to give Americans an extremely expensive lesson that their Government cannot deliver to them something that costs them nothing, and we will do that by charging 83 percent of them more for their health insurance, every one of them more for their taxes. And for what? To create a $1 trillion-plus Government subsidized program that will transfer the wealth of others to 100 million Americans.

We do not need to be subsidizing 100 million Americans, Mr. President. What kind of a country is it that says that 100 million of us are dependent upon our Government? Surely, we can reduce that figure to those who are truly in need.

Under the Clinton-Mitchell plan, health care costs do not decline but increase, according to CBO, not the Senator from Wyoming. They do not decline, but they increase according to CBO.

Is that where we want to go in the name of health care reform?

The Senator from Maine claims that the cost containment is when health expenditures remain at projected 21 percent of GDP and a few more people are covered. Medicare will have been slashed, taxes increased by $300 billion. Yet health care costs continue to rise.

It was the very need for cost control that started this debate, Mr. President, and the plan in front of us does not even address the issue. The working middle class, which the Democratic leadership is so quick to tout will receive benefits, receive the least.

To end my statement where I began, the debate over health care is a debate on the role of Government in our lives and in America. Care must be taken not to squander liberty and freedom for the elusive promises of Government benefits, and that is what we are being asked to do.

We are being asked to give up things that we now take for granted, for a promise of security that the Government cannot deliver on.

There are certain periods in America's history when pivotal decisions are made regarding the role of Government and society. Those decisions have had direct and dramatic impact on lives of Americans and set the course of the Nation for decades to come.

Many of the problems we face today arise from decisions that were made during those periods. I believe we are at another of those crossroads today. If we embark on the course that President Clinton and Majority Leader MITCHELL set for us, we will vastly increase both the scope of and the power of the Federal Government and the ability to wield influence in each of our individual lives.

Make no mistake, this Government does not seek to serve, but to control. Americans are frightened of it. We will let it control us at our peril.

Mr. President, I conclude my remarks and I ask unanimous consent that certain articles be printed in the RECORD.

There being no objection, the articles were ordered to be printed in the RECORD, as follows:

[From the Washington Post]

A HIDDEN TAX ON YOUNG PEOPLE

(By Neil Howe and Bill Strauss)

At the core of health insurance reform lies an enormous hidden tax on youth. It's called strict community rating. Politicians don't discuss it, the media don't cover it, but this multisyllabic catch-phrase threatens to move at least $40 billion a year out of the wallets of young adults (under age 35) and into the wallets of the middle-aged (age 45–64).

If strict community rating is enacted, you can ignore the talk about all the special "winners and losers" of health-care reform. The real issue will be generational. The big winners will be Clinton-aged Boomers now entering midlife; the big losers will be the young men and women now entering the labor force.

Community rating is a much-heralded reform that would prohibit insurers from charging different premiums for different individuals. In its "modified" form, it would simply ensure that no one can be charged higher premiums solely due to poor health or pre-existing conditions. This reform appeals to our sense of fairness and entails no systematic income transfer. But in its "stricter" form, it would require insurers to ignore all distinctions among individuals—including age—and charge a single community-wide fee.

The premiums an individual pays out of pocket or the health costs companies take out of a worker's compensation generally reflect this differential. After strict community rating is enacted, however, people of all ages will pay the same premium—probably, around $2,000 per year for a single person. Presto! The 25-year-old pays 100 percent more and becomes a $1,000 yearly loser. The 60-year-old pays 40 percent less and becomes a $1,500 yearly winner. For family heads, the gap will be even wider.

If applied to everyone, strict community rating would mandate a total income transfer of at least $40 billion yearly—flowing away from the 55 million adults under age 35 and enriching the 49 million pre-Medicare adults over age 45. This "reform" would be equivalent to a 7 percent tax on a typical young couple's combined wages. That would make it about as large as their personal FICA tax (through which the young are already subsidizing the health costs of seniors).

Such numbers are by no means hypothetical. Last year New York State instituted strict community rating for all small-group and individual insurers.

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Though not all the plans before Congress agree on this measure, the general outlook for young people is bleak. The Clinton, Kennedy, Gibbons, and McDermott plans all prohibit any age-based variation in the premium or taxes payable for all insurance policies covered by their plans. Average price tag: $1,000 per young adult. The Chafee and Michel plans allow a little variation, but would still cost young workers about $700 each. The Moynihan plan would allow an age variation up to a multiplier of two, thereby extracting roughly half as much ($500) per young worker. The Rowland plan and the Dole plan (which allows premiums to vary up to a multiplier of four, close to the actual cost variation) are the only major proposals that would hold the young harmless.

Few national leaders have bothered to bring this massive youth tax to the public's attention. President Clinton has said that premium variations are unjust. If so, why for health insurance alone? Teenage boys pay four times more than their parents for auto insurance because they're four times as reckless on the road—and nobody says that's unjust. Some politicians argue that community rating, like Social Security, won't take anything from the young that they won't get back as they grow older. But this argument assumes that such young-to-old income transfers are forever sustainable (something most twentysomethings already don't believe about Social Security). It ignores the trillion-dollar lifetime windfall that community rating will bestow on Bommers (who incurred no corresponding cost when they were young). And it implies that most 60-year-olds are economically needier than most 25-year-olds (which is patently false).

Hillary Clinton has advanced the brassiest argument for picking the pockets of the young. One of the big problems with the current system, she says, is the health costs that millions of uninsured young people shift onto insured older workers. In reality, this effect is trivial, certainly when compared with the cost shifting by seniors with Medicare discounts. It cannot justify talking about community rating as an appropriate penalty for the irresponsibility of youth.

Given the political invisibility of today's young adults, strict community rating could well pass Congress. If so, brace for three consequences.

First, today's young generation will become even poorer than they are now in relation to the old. Already, according to the Census Bureau, the real median income of households headed by people under age 30 is 15 percent lower than it was when Boomers were their age two decades ago. With strict community rating, their purchasing power could fall by another 7 percent.

Second, the new health law could defeat its own primary goal: universal coverage. Since adults under age 35 are currently the least insured age group in America, this goal will only be achieved if young people start purchasing more insurance. Huge premium hikes will have exactly the opposite effect. (Over the past 15 months, the New York experiment in community rating has caused a 30 percent rise in policy cancellations by young males.) The only practical remedy to this problem would be to combine strict community rating with universal mandated coverage—which would seal young people into the system, force them to buy vastly overpriced insurance, and make them even more cynical about government than they already are.

The final and most spectacular consequence of strict community rating may be political. Right now, few young adults are paying attention to health care reform. But once community rating becomes law and young wallets are emptied, that will surely

change. Come 1998, people born in the '60s and '70s will comprise America's largest generation of voters. Once mobilized, they will start deciding elections. That's when those who taxed the young to enrich the middle-aged could get run out of office by those who find themselves stuck with the bills.

Everyone knows our health-care system needs change. Costs must be controlled. Poor families must gain access to doctors. Insurers must be barred from discriminating against the sick. All this can be done without forcing all young workers to pay far more for health care (and all older workers far less) than what they actually consume.

[From the Los Angeles Times, Aug. 10, 1994]

RUBE GOLDBERG WON'T YOU PLEASE GO HOME; HEALTH REFORM: THE PATCHED TOGETHER BILLS WILL HAVE TERRIBLE SIDE EFFECTS, WITH YOUNGER PEOPLE PAYING THE HIGHEST PRICE

(By Robert J. Samuelson)

Among other things, the Democratic health-care plans contain a large—and unjustified—multibillion-dollar tax on younger workers. You wonder whether most members of Congress know this or even care. The whole health-care debate is now completely out of control. The desperate effort to craft something that can be advertised as "universal coverage" means that Congress literally no longer knows what it's doing. Anything resembling the Democrats' bills, if enacted, would produce tremendous unintended side effects.

Apparently, most Americans grasp this. In a Newsweek poll last week, respondents were asked whether Congress ought to "pass reform this year" or "start over next year." By a 2 to 1 margin, they said start over. They sense that the versions of health reform crafted by House and Senate leaders are hodgepodges of conflicting provisions whose only purpose is to win passage. But what is clear to ordinary Americans is denied in Washington. In the capital, the fiction is that legislators know what they're doing and are debating rational alternatives.

House Majority Leader Richard Gephardt's plan, for instance, would create a Medicare Part C program for the unemployed, workers in small companies and many existing Medicaid recipients. The Congressional Budget Office estimates that the program might enroll 90 million people. But the projection could easily err by millions in either direction. More important, Medicare Part C emphasizes "fee for service" medicine (patients selecting individual doctors), while the rest of the bill emphasizes "managed competition" (reliance on health maintenance organizations and similar plans).

The bill would separate the under-65 population into two groups, mainly based on income and size of employer. Each group would be crudely steered toward a different type of medicine. In practice, this division may not be politically acceptable or economically workable. Gephardt doesn't know; no one does.

Now, consider the tax on young workers. It arises from "community rating." As people age, their health costs and insurance premiums rise. But community rating requires that everyone pay the same rate. This provision is included in the House bill and, in a modified version, in the Senate bill. The effect would be to raise insurance for younger workers (say, those below 45). If employers have to pay higher insurance, they will pay lower salaries. The invisible tax on young workers might total $25 billion annually.

Questions swirl around both Gephardt's plan and Senate majority leader George Mitchell's. It is hard even to describe Mitchell's plan. He says it's voluntary and lacks a "mandate." Wrong. True, it doesn't mandate companies to buy insurance for workers. But it does mandate a standard benefits package for firms—the vast majority—that offer insurance. Because the mandated benefits are above average, this would probably raise health spending. Companies below the new standard would increase benefits; those above would have trouble lowering them.

Next, Mitchell hopes to achieve 95 percent insurance coverage by offering subsidies for low-income workers to buy it. But there's a "fail-safe" mechanism to limit subsidies if the budget costs exceed projected costs. However, if 95 percent coverage doesn't occur by 2000, Congress could require employers to pay 50 percent of their workers' insurance. But this would apply only to firms with more than 25 workers. Got it? No one knows whether this would reach 95 percent coverage.

These plans are confusing because the health debate evaded the basic tension between expanding health services (universal coverage, etc.) and controlling health spending. It's hard to do both at the same time. The plans' complexities—as with the original Clinton plan—aim to disguise this conflict. Republicans haven't been especially constructive in this debate, because they haven't faced up to it either. But they are now correct that a bad bill would be worse than none.

Chaos is now the most important reality about the health-care debate. Dozens of provisions in these bills would have huge unappreciated consequences. John Sheils of Lewin-VHI, a health consulting firm, says premiums for small businesses in the Mitchell bill could be 25 percent higher than for big companies. The budget office puts the gap lower. Who's right? Do most members of Congress understand the gap? Probably not. Still, the pretense is that Congress is making conscious choices.

The pretense is sustained because in Washington politics is sport. All attention fixes on who wins and loses—and the deals that enliven the game. Rhetorical blasts are taken for reality; political reporters know little of how legislation would work and care less. This often leads to bad laws, and in health care, the potential for blunders is huge because Congress is tinkering with one-seventh of the economy and most aspects of medicine.

In May, Robert Reischauer, head of the budget office, warned that trying to find a compromise by combining provisions from different bills might make the health system worse. He compared it to building an auto engine with incompatible parts: "You can't say I want a piston from Ford, a fuel pump from Toyota . . . and expect the engine to run." Well, that's what's happened. The contraption is part car, part tractor and part rollerblades. Most Americans seem to understand this. Will Congress?

[From the Washington Post, Aug. 9, 1994]

A HIDDEN $100 BILLION TAX INCREASE

(By Martin Feldstein)

President Clinton is increasing the pressure on Congress to enact a massive and irreversible entitlement program to subsidize health insurance and redistribute income. The tax cost for this largest-ever welfare expansion would top $100 billion a year at today's prices. That's equivalent to raising personal taxes across the board by nearly 20 percent.

Amazingly, the Senate Democratic leadership has managed to conceal this massive tax increase from the public. The legislative wrangling and public discussion have virtually ignored the cost of financing this spending explosion. Members of the business community have been so eager to avoid employer mandates that they have not considered the tax consequences of the pending legislation. And members of the general public have been so concerned about preserving their ability to choose their own doctors that they have not focused on what these plans would mean for their individual wallets.

CBO ANALYSIS

Although the Democrats have yet to agree among themselves on the details of the final plan, it is likely to be closely related to the Senate Finance Committee bill. (The recent proposal by Senate Majority Leader George Mitchell that President Clinton said he would accept is essentially an expanded version of the committee's plan.) To understand the magnitude of the potential tax hike that would be required to finance such a plan, it's useful to look at the Senate Finance Committee bill and the recent analysis of it by the Congressional Budget Office

Under the Senate Finance Committee plan, the government would pay the full cost of a standard private insurance premium for anyone below the poverty level and would provide a partial premium subsidy that declines with income between the poverty level and twice that income. The insurance premium would vary with family composition but would average about $2,000 per person. A single parent and child would receive a subsidy with income below $20,500, while a couple with three children would receive a subsidy with income up to $37,700.

More than 60 million individuals would be eligible for subsidies in addition to the 60 million already covered by Medicaid and Medicare. The Senate Finance Committee plan would raise insurance coverage by about 21 million individuals, bringing total coverage to 93 percent of the American population.

The budget analysis prepared by the CBO never states its estimate of the total additional cost that taxpayers would have to bear to finance the new insurance subsidies. But the CBO figures do imply that the public would be paying about $63 billion a year (at 1994 prices) by the year 2000 when the plan is fully operational, and estimates that I have made with the help of colleagues at the National Bureau of Economic Research indicate that the CBO figure understates the true cost by about $40 billion a year.

Most of the $63 billion tax burden implied by the CBO numbers is hidden in cost-shifting through insurance companies and providers of health services. Only a relatively small part of the financing plan is an explicit increase in the tax on tobacco products. A second small piece is a 1.75% excise tax on private health insurance premiums. Although this tax of $7 billion a year (at 1994 levels) would be paid by the insurance companies, they would pass it on in the form of higher premiums.

These higher premiums would be a direct tax on individuals who buy their own insurance. Companies would offset the higher premiums on the insurance that they provide to their employees by keeping wages lower than they would otherwise be. The true burden of the premium tax would therefore fall on everyone who is now privately insured.

The largest part of the financing is a hidden tax that is built into the plan to replace the current Medicaid program for the poor by subsidized private insurance. Medicaid

provides much more generous benefits than the proposed standard insurance package, since Medicaid covers a broader range of services and has no out-of-pocket copayments. Although the government would pay the insurance companies the same subsidies for former Medicaid beneficiaries as it pays for everyone else, the proposed law would require the insurance companies to provide those who are currently eligible for Medicaid with the much more expensive coverage that they have today.

That complex maneuver would save the government about $29 billion a year on the current Medicaid program and would add that amount to the annual costs of the insurance companies. The insurance firms would in turn shift it to everyone who is privately insured in the same way they would shift the explicit premium tax.

A second very large hidden tax would result from reducing government payments to hospitals and other providers of Medicare services without any reduction in the care that they are expected to give. As a result, the hospitals and other providers would just raise their prices to patients and insurance companies. In the end, it would be the privately insured individuals who bear those costs in the form of higher insurance premiums and lower wages. At 1994 levels, this cost-shifting burden is equivalent to at least a $13 billion annual tax.

In short, buried in the CBO numbers is a projection that the Senate Finance Committee plan would have a $63 billion annual cost (at 1994 price levels) and that all but what the CBO estimates to be $14 billion in cigarette levies would be obtained by hidden taxes in the form of cost-shifting through health care providers and insurance companies.

It's remarkable that the same politicians who have produced this $49 billion in hidden cost-shifting have the audacity to say that the public should support their plan in order to eliminate the much more limited cost-shifting that occurs under the existing system as hospitals pass on the cost of free care. Indeed, to the extent that hospitals are already giving free care, the increase in formal insurance coverage gives that much less to the currently uninsured and confirms that most of the plan's cost is to achieve income redistribution, not expanded health insurance.

The CBO report is careful to note that its estimates are "preliminary" and "unavoidably uncertain," and fully half of the report is devoted to discussing why there is "a substantial chance that the changes required by this proposal—and by other systemic reform proposals—could not be achieved as assumed."

My own analysis confirms that the CBO's caution is justified and that the CBO estimates understate the likely annual cost by at least $40 billion that would eventually have to be financed by higher taxes. A key reason is that there is no way to limit the premium subsidies to those who are currently uninsured. Those who are now buying their own insurance would automatically receive the government subsidy. Those who now receive insurance from their employers could qualify for an insurance subsidy by switching to an employment situation that paid higher cash wages instead of providing health benefits.

That subsidy would be worth a very significant $2,000 for a single mother with a child who earns $15,000; if she earns $10,000, the subsidy would be worth more that $4,000. It wouldn't take long for employers and employees to recognize that some combination of new pay arrangements, explicit outsourcing of some work, and individual job changes would be handsomely rewarded by the government.

There are now more than 30 million individuals who could qualify for a subsidy. The CBO estimate recognizes that the roughly six million of them who now buy their own insurance would receive government subsidies. But when it comes to those who are already insured by their employers, the CBO assumes that only about one-fifth of the income-eligible group would eventually choose to qualify for the subsidy, leaving $27 billion of potential subsidies (at 1994 levels) on the table. It seems totally implausible to me that employees and employers would permanently pass up subsidies of $1,000-plus per person that they could get by relatively easy changes in employment arrangements. When they do choose to qualify, taxpayers would have to pay an additional $27 billion to finance the plan.

The CBO calculation also ignores the effect of the subsidy phase-out between poverty and twice poverty on the incentives to work and to report earnings. The phase-out rule that gives a woman with a child $4,660 of subsidy when she earns $10,250 and then takes away more than 40 cents of subsidy for every extra dollar that she earns is a powerful incentive to work less and to shift work to the underground economy.

The CBO's report acknowledges that "the effective marginal levy on labor compensation could increase by as much as 30 to 45 percentage points for workers in families eligible for low-income subsidies" so that "some low-wage workers would keep as little as 10 cents of every additional dollar earned." But then, quite incredibly, the CBO calculations do not take into account that this would reduce reported earnings, thereby cutting income and payroll tax receipts and raising the health insurance subsidies for which individuals are eligible. Estimates made at the NBER indicate that these reactions would reduce taxes and increase subsidies by a combined total of at least $17 billion a year.

This estimate makes no allowance for the impact of increased demand on health care costs in general. Extending insurance to at least 20 million people who are currently uninsured and giving private insurance to the more than 25 million nonaged Medicaid beneficiaries would inevitably raise the demand for health services and increase health care prices. But even without that, the analysis that I have laid out shows that the Senate Finance Committee bill would cost the American public more than $100 billion a year at today's prices. The Clinton-Mitchell plan for even broader coverage would cost even more.

INCOME REDISTRIBUTION

A cost of $100 billion-plus a year to increase the number of insured by 20 million means a cost to the taxpayers of more than $5,000 for each additional person insured—a cost of $20,000 for a family of four. Since the actual insurance premiums are $2,000 per person, it's clear that most of the tax dollars in these plans are for income redistribution rather than the expansion of insurance coverage.

The most fundamental social program in a generation should not be enacted without full and careful consideration of its costs. Once enacted, the benefits would be an irrevocable entitlement for nearly 100 million people.

The ability of the politicians to hide a $100 billion-plus tax increase is both amazing and frightening. Using mandates on insurance companies or mandates on all businesses as substitutes for direct taxes destroys the budget process and provides a ready way for politicians to deceive the voters. The politics of tax and spend has entered a new era when politicians can spend $100 billion a year and hide the taxes that we pay for those outlays.

If President Clinton and his congressional allies succeed in ramming this legislation through Congress in the weeks ahead, the American people will have lost not just $100 billion a year. We will also have lost our ability to check the excesses of the political process and to unmask the chicanery of the politicians.

It political leaders want to deceive the voters, the only safeguard is a democracy in which long and careful public debate and congressional hearings can expose such deception. Although Congress has held hearings on the now defunct Clinton plan and on the broad issues of health care, there has been no serious consideration of the cost and financing of the plans that have recently emerged. The American public deserves a chance to know what we are being asked to pay and what we will get for our money. We should be suspicious of any politician who says there isn't time for such a careful examination.

[From the Wall Street Journal, Feb. 1, 1994]

GERMANY IS NOT A MODEL

(By Wilfried Prewo)

"We have a lot we can learn from the Germans," President Clinton said recently, trying to sell his health care plan. "The Germans are able to provide a very high-quality health care system at a much lower cost than we are, because they have much more discipline in the way it's organized and financed." In an address to the National Governors Association yesterday, German Chancellor Helmut Kohl said that in the "run-up" to America's health care reform, "there was an intense exchange of opinions between American and German experts.

On the surface, the German system does indeed look good: It insures society comprehensively and gives individuals quality coverage that is permanent and portable from job to job. Germany spends about 10.6% of its gross domestic product on health, as opposed to about 14% spent in the U.S.

But simple comparisons are misleading. Germany and the U.S. differ greatly in aspects not controlled by doctors and hospitals, such as crime-related injuries, malpractice insurance and nursing care for the elderly. It is worth noting, too, that the costs of Germany's plan have risen by a sharp 23%, after inflation, over the past three years. It pays to take a good look at the German system before prescribing it in the U.S.

STRIKING SIMILARITIES

The similarities between the Clinton plan and the German systems are striking. The president wants universal coverage; Germany has nearly achieved that. German law mandates that everyone enroll in the health insurance system, with the important exception of higher income earners making more than $3,300 a month. The opt-out income level is set relatively high so that about 14% of Germans must join. Another 14% voluntarily join or stay in the statutory health system although their income has risen beyond the cutoff. About 10% (high-income employees, self-employed) have private insurance, and fewer than 1% have no insurance.

Regional health alliances, a big Clinton idea, are the cornerstone of the German system. Companies with more than 1,000 employees (5,000 in the Clinton plan) have the option of forming a corporate alliance. These roughly 1,000 regional or other alliances are the monopoly buyers of medical services for the 88% of Germans who belong to the statutory system.

The Clinton team wants a system that guarantees identical benefit standards for all alliances: the American debate over coverage for mammograms and prostate cancer tests already gives a whiff of how controversial the contents of this list will be. In Germany, which already has such unified standards, the contents of the list are so important they can affect elections: coverage of abortions, for example, will play a role in elections this year. The net result, Germany shows, is that the list simply grows over the years.

Germans pay for their plan through what is essentically a payroll tax, just as the president would have Americans do. Employers and employees in Germany each pay half of the tax [rather than the 80%-20% split proposed in the Clinton plan]. The tax rate differs among the alliances, ranging from 8% to 16.8% of payroll (aggregate of employer and employee share), with an average of 13.4%. Yet Germany's program gives us clear evidence of the degree to which this system lends itself to abuse. Once their tax is paid. Germans graze themselves to obesity on medical services. The Clinton plan has the same bias toward excessive individual use of medical services—at the expense of all members of an alliance.

The German system's major fault is that it doesn't put people first, in the sense of building on individial responsibility and control through effective copayments and other incentives to save. It is interesting that corporate alliances, organized by companies that have an interest in holding their own 50% share down, typically have premiums far below the average regional alliance.

The Clinton plan's critics believe that this system also strengthens bureaucracy. The German plan proves them correct. While the alliances were originally devised as nongovernmental health plan purchasing cooperatives, they have degenerated into de facto government agencies. Some 112,000 employees in western Germany alone work for alliances, their administrative costs per member having risen by 53.3%, adjusted for inflation, from 1982 to 1992. This is more than the increase in the alliances' total health costs, revealing that the disease of bureaucracy is the real problem.

The Clinton plan's critics also fear that it will quickly become a single-payer system. In effect, Germany's has already become one, financed by the payroll tax (for the 88% in the statutory system). Patients do not see a doctor's bill. Thus, they have no way of realizing whether the charge for a service has been particularly expensive, or even whether the service has actually been rendered. The doctor sends his bill to his regional association of physicians as the financial clearing house and counterpart of the patient's alliance.

Hidden taxes, a flaw in the Clinton plan, are already part of the German plan. Because the average German carries only 50% of his health care costs directly, he is aware of only his 50%, and increases may not bother him too much. But the 50% the employer carries is reflected in overall labor costs that make Germany the second-most-expensive country in the world to employ people (after Switzerland), and one with higher unemployment than the U.S. Under the planned 80% employer costsharing in the Clinton plan, this labor-depressive effect would even be more pronounced in the U.S.

Cost-sharing and lack of incentives to save form a potent drug driving health costs up. Unobserved, hidden taxes grow. The German payroll tax rose from an average of 6% in 1950 to 8.4% in 1960 and 11.0% in 1980, before reaching its current 13.4%.

Financially, the German plan is also no model. For 20 years, it has vacilated between financial distress and collapse, and the government has intruded with evertighter regulations. Since 1977 alone, there have been nine federal laws trying to curb costs. German measures to control costs foreshadow the results of the Clinton plan: price controls and control of supply.

Last year, physicians, dentists and prescription drugs were each, as a group, subjected to narrow budget caps, and tight regional quotas now limit the number of doctors allowed to practice under the system. The physician associations have to police their members with respect to "excessive," above-average services. More cost-effective—particularly corporate—alliances now have to cross-subsidize high-cost alliances, thus rewarding inefficiency in the name of solidarity. Prudent insured people and prudent doctors are still not rewarded for cost savings in the form of lower premiums or bonuses. Needless to say, all reform attempts have missed their targets.

Although only 10% of Germans are covered by private insurance, it offers some obvious lessons for everyone. First, payroll taxes in the statutory system are 25% higher than private premiums, since private insurers compete vigorously. Their benefits are better, and the administrative cost per insured person is only half. Second, the private alternative forces the statutory system to improve, within limits, since otherwise its voluntary members would opt out for private insurance. This beneficial effect is indirectly evidenced by the larger inefficiencies in countries that force everybody into a statutory system.

Maybe the Clinton team looked at various statutory systems and concluded that Germany's looked best. The one-eyed is king among the blind. But why does the president want to emulate the 90% of the German system that is failing instead of the 10% that is effective?

WRONG ABOUT COSTS

Perhaps the most interesting revelation from the German plan, though, is that it shows how unrealistic Mr. Clinton's is. In the U.S., the maximum premium to an alliance will be about 10% of payroll. This is supposed to pay for health costs that now amount to 14% of GDP, set to rise to 17.3% in the year 2000 under the Clinton plan's reform projections (18.9% otherwise).

If a 13.4% payroll tax in Germany is needed to finance 10.6% of GDP, it is hard to conceive how, in the U.S., a much smaller payroll tax of 10% can finance U.S. health care costs at a much larger share of 14% to 17% of GDP. The missing gap is too large to be filled by the designated subsidies and sin taxes. If you want to copy pages out of the German social policy book, have your checkbook handy.

Mr. WALLOP. I thank the Chair.

The PRESIDING OFFICER. The Senator from New York [Mr. MOYNIHAN].

Mr. MOYNIHAN. Mr. President, before the Senator necessarily leaves the floor, may I tell him how much I have enjoyed his critique. It is a careful and analytic tradition that deserves to have a place in this body, and it has been very ably filled for 18 years now by the Senator from Wyoming.

Could I make just one comment about the point he makes of the 1.75-percent tax on health care premiums for academic health centers and research? This originates in the Finance Committee, as he knows, and knows well—he is a very distinguished member—and it comes about in one of those ironies of progress.

I cannot doubt that the Senator has followed the works of Joseph Schumpeter over the years and his particular notion of creative destruction of capitalism, that as advances are made existing institutions find themselves bypassed and indeed often destroyed.

One of the things we learned, and as we learned this, it took a while for it to sink in on the chairman. I must say that, because the health maintenance organizations are making such progress, because cost containment is becoming a large managerial function in the United States—cost containment and health care, an activity that probably did not exist 20 years ago but now firms traded on the stock exchange do this, and they do it and they perform and they are rewarded in relation to their performance and very conscious of cost.

This has made them reluctant to send patients to hospitals associated with medical schools. Academic health centers is the term we use. There are States in the Nation which we associate with being advanced as regards coverage in health care, and whose universities are world renowned, whose medical schools may close because of this new situation.

The cost containment is good, but it will not last long if those medical schools close and the people who bring about the new technologies and the extraordinary advances in medicine are not trained.

We had—I hope my memory serves correctly—the director of the hospital for the University of California in Los Angeles, Dr. Shultz, who said their occupancy ratio now is about 45 percent. There is a spot market in southern California for bone marrow transplants, and a vast university is half empty.

It is in response to this that we felt that there has to be, there needs to be, and a case can be made for, providing a trust fund with a steady stream of income to our academic health centers so that we shall have coming out of them a steady stream of doctors, nurses, and research scientists that has made this moment the greatest moment of discovery in the history of medicine. It is this moment, and it is taking place in this country and in those institutions.

I want to make that point.

Mr. WALLOP. Mr. President, will the Senator yield?

Mr. MOYNIHAN. I am happy to. I yield the floor.

Mr. WALLOP. I do not quarrel with the goal of the Senator from New York. I do quarrel with Government's role. I made three points earlier. One is that it doubles the money now being spent by the Government, and still $10.8 billion is not accounted for. That is being tossed off into just general revenues, I guess.

Mr. MOYNIHAN. That is where we are going to have that one in Casper.

Mr. WALLOP. In Casper? I am brought on.

But there is another problem. First of all, Government may be better at this—and I will accede that to the Senator—than it is in many things that it contributes money to. But it is a long way from perfect, and the problem is that it says to the great private contributors of this country: "Forget it, boys. Government's role is to do that now. We are out."

I have said more than once that the more secular this country becomes, the more we pray to Government to do that for which we used to pray for our Maker to do or to provide. What happens is that as we have increased welfare programs and everything else, the private community conscience has diminished co-equally. We spend less in taking care of the disadvantaged in our little homes and houses and communities than we did, because it is Government's job.

I just do not think it is wise at this moment in time to tax every American 1.75 percent to take care of teaching hospitals. I do not quarrel with even keeping where we are at the present level, although we seem to be doing that without a premium tax. But it strikes me that the worst thing we are doing is saying, OK, you do not have to worry anymore, Government will. Government picks up all the worries that are there. Therein becomes the kind of losses that I think are inherent in a system—too much and too corrupt.

So it is a difference of opinion as to what Government's role is. It is certainly not a difference of opinion on the goal.

Mr. MOYNIHAN. No.

The PRESIDENT pro tempore. The Senator yields. The Senator from New York is recognized.

Mr. MOYNIHAN. Mr. President, may I again thank the Senator from Wyoming for his balance and courtesy and clarity in these matters.

My purpose was not to dispute that he has a case. I do not know but if we quantified charitable giving, I think we would find it goes up. I think we would find it is more a function of total resources than individual sense of obligation.

ADDITIONAL REMARKS BY SENATOR WALLOP

Mr. WALLOP. I would like to clarify for the RECORD that the figures quoted from the Joint Committee on Taxation distributional charts were misinterpreted. Instead of individual numbers, they are aggregate numbers. I hope to have individual numbers available in the next few days that should clarify the amount.

As I noted, however, with respect to the 1.75-percent premium tax, taxpayers with incomes of $50,000 or under will pay 54 percent of the net tax increase, while taxpayers with incomes of $75,000 or less will pay 79 percent of the increase. Regarding the four taxes mentioned, the Joint Committee's distributional charts show that taxpayers with incomes of $50,000 or less will pay 60 percent of the net tax increase, and taxpayers with incomes of $75,000 or less will pay 78 percent of the new taxes. Hefty sums, in either case.

But leaving that aside, I just want to draw attention to something which is in our report I have here, "The State of America's Health Care System and Health Care Crisis." I am going to make a bet that one crisis you will not read about is the crisis of the financial viability of the teaching hospitals and the medical schools. It has come about right suddenly, unexpectedly, and it is important. And as long as we know about it, I think we will, in the end, make some useful efforts to deal with it.

Mr. President, I yield the floor. I see a number of my colleagues have been waiting. The Senator from Washington has been patiently waiting to address the Senate for some time now.

The PRESIDENT pro tempore. The Senator from Washington, Senator MURRAY.

Mrs. MURRAY. Mr. President, I have listened very carefully and I have waited patiently as we have debated the health care reform bill. I know the majority leader laid down this bill 2 weeks ago, that we have had 6 long days of debate, and I know that the Dodd amendment has been on this floor for 4 days.

I came to the Senate a year and a half ago and I was eager and anxious to get to the heart of the problems that many of the families that I talked to throughout my campaign told me about, and health care was at the top of their list. I am frustrated today that, despite having this bill on the floor for 2 weeks, not one amendment has been voted on on this floor.

I have heard many of my colleagues state that they disagree with parts of the Mitchell bill. That is part of the political process. I have heard their criticisms of cost containment or benefits packages or new programs, and that is their right. But it was my understanding that when someone disagreed with a part of a bill on the floor, that they had the alternative to propose an amendment and it was up to us to look at that, debate that amendment, and agree or disagree—vote amendments up or down and ultimately come to a final bill that we would either pass or not pass, depending on what was in it.

But so far, we have not gotten there. For 4 days, the Dodd amendment that would provide benefits for pregnant women and children has been on this floor. And this delay has not been without cost. In the 4 days that this amendment has been on the floor, 2,544 babies were born to mothers who received late or no prenatal health care. I urge my colleagues to get on with this debate.

Even more troubling to me as I have listened to many of the speeches over the last 6 days is the people who say, "Just say no." I think it is time we remember why we got to this health care debate and why it is a critical topic in this country. There has been an increasing number of hard-working families in this Nation who cannot afford health care in today's world. It is not provided by their employer, they have been opted out because of preexisting conditions, they have changed jobs, they have moved, and they have found themselves in a position where they cannot purchase health care.

They call up an insurance agent and he says to them, "No, sorry; you are out of luck." Under the Mitchell plan, we seek to reduce that risk for families so if a preexisting condition exists, you can still purchase health care. Under the Mitchell plan, there will be subsidies for families who do not have the means to go out and purchase health care. These are important steps in the right direction that this Nation needs to get on with.

We are here in this debate today because of the increasing cost to everyday families out in the real world. As they get their health care insurance bills—and these are people who have insurance today—they see that their deductions have skyrocketed, their copayments have risen, their premiums have gone up, and their benefits have been reduced. And there is no security that that is not going to change when they get their next bill. The Mitchell bill seeks to provide some security and assurance to those people who have health care insurance today, and it is time to take that step.

We are here in this debate because of the increasing cost health care is to our entire system, to families, to businesses, to government. As a former State senator, I know we were unable to provide more teachers for our classrooms and policemen for our streets because an increasing part of our State budget was going to health care costs. None of the plans are perfect but certainly it is time to take a step in the right direction.

What has troubled me the most throughout this debate is the statements I hear that, "Well, only 15 percent of the American people do not have health care, so let's not mess it up for the 85 percent."

Mr. President, we have a responsibility to assure that those 15 percent of Americans have health care insurance. But we also have a responsibility to those 85 percent who have insurance today, to provide them security. And that is what the Mitchell bill seeks to do.

I hear statements if health care reform, any health care reform passes, we will have long, long waits. We do not now? Ask any parent who sat in an emergency room on a Friday night, like I did recently with a daughter who sprained her ankle in a Friday night soccer game. We sat there for 6 hours. Those are not long waits today, under the current system?

I looked around that health care emergency room as we sat there. I would urge all of my colleagues to go sit in an emergency room and watch what comes in the door. I saw young mothers with young children who were there because their child had a cold. I saw others who were there with general health care problems who should have been seeing a physician in the doctor's office during the day. But I talked to a few of them and they were there in the emergency room because they did not have health care coverage. This bill will eliminate some of those long lines in our emergency rooms, and it will save money at the same time. It may not be perfect, but it is a step in the right direction.

What is most troubling to me are some of the statements that I have heard about how bad government is, "Government has taken over everything; isn't that awful?" Mr. President, I am very afraid for this country if we continue to denigrate government as we have heard over and over again. If the people of this country do not make the decisions for ourselves through a representative democracy, let us ask who will make the decisions? Large corporations? The insurance companies? The wealthy? It is time for us to be a part of that representative democracy and forge a bill together that assures all Americans have access to health care reform. That is the kind of democracy I believe in. That is the kind of government I believe in. And I believe that is what this debate is all about.

And, bureaucracy—what a word. It is intimidating, it is frightening, it is scary. But I submit, one man's bureaucracy is another woman's assurance of quality health care in this country.

I hear the word "bureaucracy" thrown out and I look in this bill to what we are referring to. And perhaps we are talking about the long-term health care provisions in this bill that provide grants to States, matching grants, so that they can put in place long-term health care for our elderly citizens, so that instead of having to go to a nursing home as they get older or become sick, they can stay in their homes and have the kind of care that will provide them the dignity that they deserve.

Mr. President, I believe it is time to remember the American people. I came here to bring change, and change means we listen to the American people. Maybe change is not comfortable for everybody, but it does mean renewed hope for thousands and thousands of American citizens. And we should take some risks and put a program out there to provide hope for thousands of Americans today.

People are tired of waiting because the current system does not work for too many of us. Like many of my colleagues, I have received hundreds and hundreds of letters over the last years about the health care crisis, and I want to share a few of those with you.

I have one from Kent, WA, a young mother who says:

> A year and a half ago, just as most people in our Nation were beginning to look closely at the issues of national health care, our family plunged head first into our own health care crisis and was forced to meet many of those questions head on.
>
> At that time, our daughter, Tara, who was 8 months old, was diagnosed with severe combined immunodeficiency disease, which is a rare genetic disorder.

She describes in her long letter the painful decisions that she had to make. She talks about preexisting condition; the fact that her daughter, 8 months old, will never be able to change policies in this country because she now has a preexisting condition. And she says they will not be able to move or change our jobs because of what has occurred in our lives. She talks about the fact that she had to fight with her health care insurance company to get coverage for her child. If that is not bureaucracy, what is?

She says:

> No parent or patient should be forced to argue these kinds of issues, especially in the middle of a crisis.

But instead of caring for her daughter, she found too often that she was having to fight with her insurance company, and that is a sad note in this country.

There is much in the Mitchell bill that we agree with or disagree with. But, Mr. President, I submit to all of my colleagues, it is time to move on. It is time to get to the amendment process, and it is time to make a difference for thousands and thousands of Americans in this country.

It is time to get on with this long-winded debate, Mr. President, because, frankly, it has become more painful than my last 6-hour wait in the emergency room.

I thank my colleagues.

Several Senators addressed the Chair.

The PRESIDENT pro tempore. The Senator from Ohio [Mr. GLENN].

Mr. GLENN. Mr. President, I rise to comment on the Dodd amendment and also on the Mitchell proposal on health care reform.

I am pleased to have this opportunity to speak in support of the amendment offered by our colleague, Senator DODD, which would increase health care for our Nation's children and, at the same time, help curb unnecessary health spending.

Our distinguished colleague from Washington talked about being in a hospital waiting room. I do not know how many of you may have visited a children's hospital recently. But if you have, you have seen the underweight babies, the preemies, those with birth defects, those who are starting out in their first days of life with one strike against them, those at risk, those for whom enormous expenditures will be incurred and could have been prevented with a little better health care.

Talk to some of the parents who are there with terror in their hearts at seeing some of these problems with their newborn, with whom they looked forward to sharing a new life. They literally have terror in their hearts because they know the problems that lie ahead, and we know that many of those situations could have been prevented.

The amendment we are considering improves upon Senator MITCHELL's health care reform bill by accelerating the date on which insurance companies would be required to include preventive services for pregnant women and children in insurance policies.

This is not something new. This is not some untried, fictional-type proposal. It is used now in 16 different States and the District of Columbia. This is something that I think could well be supported on both sides of the aisle. I note in the list, the State of Kansas has had a provision like this in its own law since 1978; Louisiana, 1992; Wisconsin, 1975.

So this is something that has been tried. It is already mandated in insurance packages in those States, they are provided in plans offered through the Federal Employees Health Benefits Program also.

One of the basic reasons they are provided is very simple: They are cost effective. By providing low-cost prenatal care and well-baby care and immunizations, we can avoid the human suffering and the high cost associated with low-birth-weight babies and children whose illnesses become more severe and ultimately more costly when they are left undiagnosed and untreated.

An important goal of our health care reform debate is to ensure that all Americans have private health insurance which emphasizes primary and preventive care. By providing these services to pregnant women and young children, we can reduce our intolerably high infant mortality rate and ensure a healthy start for all of our children.

Mr. President, we have in this country the finest health care in the world.

We have the finest health research in the world. We have the finest pharmaceutical companies in the world. Yet, our infant mortality rate ranks 22d among nations of the world. There is a great disconnect here. We have the best of everything except it does not get to everybody. It is not distributed, so it is never used in those particular cases. All this amendment does is say that those in the first stage of life will get a shake at the best health care and the best preventive health care that we can offer.

Twenty-second in infant mortality, let me repeat that again. We should be absolutely ashamed of that. We are the greatest, the richest, the strongest economic nation in this world, and yet we are 22d in infant mortality.

Along with the reforms in the Dodd amendment, we need to work to ensure that all Americans are able to purchase private health insurance. I believe Senator MITCHELL's bill would make this possible by making insurance more affordable and providing subsidies to help low-income individuals and employers purchase insurance.

So I urge my colleagues to complete debate on the Dodd amendment. Let us adopt it and move on to other important amendments to Senator MITCHELL's health care reform proposal. I think the time to act is now.

Let me back this up with some other statements. What is the price of delay? The Senator from Washington touched on a couple of these items. I would like to give a couple more.

Just during the time the Senate has been considering the children-first amendment, as it is called, children across this country have continued to suffer. Just in the 4 days the Senate has considered this pending amendment, it is estimated that 2,544 babies were born to mothers who received late or no prenatal health care, and 3,204 babies were born at low birth weight. That means less than 5.5 pounds.

Two hundred twenty-four babies died before they were a month old and 440 babies died before they were a year old. That is just in the last 4 days.

Prevention does pay off. It is estimated that for every $1 spent on prenatal care, it saves $3.38 on the care of low-birth-weight infants. Every time a low-birth-weight delivery is prevented, it saves between $20,000 and $50,000 in costs, and every time a very low-birth-weight delivery is prevented, it saves approximately $150,000 or more on neonatal intensive care costs. Routine preventive checkups can avoid hospitalizations that may cost as much as $600 a day.

So, Mr. President, I urge my colleagues to complete debate on the Dodd amendment. Let us pass it and let us move on to the other important amendments. The time to act truly is now.

Mr. President, I would like to continue by making some general remarks not just on the amendment of Senator DODD but on the proposals by Senator MITCHELL.

I guess we all have our views formed to a large extent by our own personal experiences, our background. We have many examples of this. We have heard time after time on the Senate floor in the last few days from people who get up and say something about their own personal family experience or their own personal experience of having cancer themselves of one kind or another and how they had to deal with it. So I guess we are all a product, at least in part, of our past experience. I can go back to my own days as a younger person in New Concord, OH. I knew a couple there. This was back in the early 1960's, I might add, just before the Medicare came into being.

Of the couple I knew, the husband ran a plumbing shop in New Concord, OH, and worked very hard. His wife took care of the plumbing shop while he was out working. They saved a very modest amount for retirement, retired, and 2 years later one of them came down with cancer. That man and his wife saw all their lifetime savings go in the first 2 years. A lifetime of hard work that went down the tubes.

Well, I put this in the third person, but it is not really a third-person story because that couple was my father and mother. So we take some of these things very personally and they affect our views for the rest of our lifetime, and I have thought ever since that time that we can do so much better in sharing some of these dangers together.

Now, granted, we have Medicare and that protects some of the people in their senior years, but how about people who have not quite reached their senior years yet? How about people that cannot afford insurance? I cannot imagine a more horrible feeling than having a child or a father or a mother and seeing that person in need of medical attention and not being able to get it. Knowing that health care is down the street but not being able to afford it, or seeing a child or a family member suffer and maybe die because of not being able to afford it. I cannot imagine anything much worse than that.

So we see these personal experiences, and do they affect our views on health insurance? Yes, they certainly do. They affect mine because I have believed ever since those days we could do better than we are doing with regard to health insurance.

Why do we need reform? Some say we do not need it or we need as little change as possible; we have the best system in the world; we have the best research in the world; we have NIH; we have the best medical schools in the world; we have the finest drug and pharmaceutical companies; they are doing research; they are providing medicines. We must do no harm to a system that is the finest medical care system in the world.

Then we have to look into it a little bit, and what is going on with the coverage that we have for this finest medical care system in the world. Well, 218 million Americans do have health insurance. That is fine. Some are not adequately covered but they have a policy. They have something. We have 37 million Americans who do not have health insurance. They are the havenots or they are between jobs or they are locked in. They have a preexisting condition and cannot get insured, or they have all the reasons why they do not have insurance.

Well, if we look at that overall ratio, maybe that is not so bad for a country like ours, 218 million Americans have insurance, 37 million Americans do not. But I submit that is not very good compared with our industrial competitors around the world. Do you know how long the Germans have had full coverage health insurance? It is 110 years—into the last century; Japan, since 1920; France, since 1928. These are basically government plans, single payer. I am not proposing that we go to that. Our system did not develop that way. We did not develop that kind of a system in this country. We developed along an insurance route. We developed an independent insurance industry to do some of these things.

So when we say the Germans have had their plan since the last century, Japan since 1920, and France since 1928, so what? We do not have to follow them, that is true, no matter what their basis is. We have developed our own system in this country, and it has been a good system. It has worked pretty well up to now.

Up to now. This is the important point. We are truly at a crisis stage, and that is not something that is manufactured by those who are promoting health reform. The problem is that costs are escalating, and for those 218 million Americans who have policies, they are not going to cover their family adequately into the future.

That is what is really driving this. It is not necessarily the concern that we all have for the 37 million Americans who have no insurance. It is the 218 million Americans who write in and say, "I just looked at my policy, and it does not cover my family anymore. What am I going to do about this?" Costs are going up. The 37 million Americans who do not have health insurance, if they have a problem, they go to the emergency room. That costs something. They cannot pay. The costs of running that emergency room then are put back on the other 218 million in their insurance policies and increased costs.

So the costs are driven up for the 218 million. Where do we stand? Why is this a crisis? Health care costs now as

a proportion of our gross national product are estimated to be just approaching 15 percent. Do you know that by the year 2003 it is estimated to go up to almost 20 percent? That is of our whole gross national product, everything.

What does it do just to Federal expenditures? Right now, it is at 17 percent. It is estimated that by 1999, just in 5 years, it will go up to 24 percent.

Now, that is a 41 percent increase at the Federal level and almost a one-third increase as a percent of our GNP. They say, well, these are just figures, but I will tell you the one area where the figures have been reasonably accurate in the past has been estimates of health insurance costs.

Let me quote from an editorial in yesterday's paper because this points out exactly the point I just made, that costs are going to go up for everybody, not just for the 37 million Americans who do not have health insurance. They are not going to be the only ones who have a problem. I quote from yesterday's editorial:

> Meanwhile, the cost of health care continues to soar—and the higher it goes the greater number of people who lose insurance because neither they nor their employers nor the Government can afford it. A seventh of all the money Americans have available to spend today goes into a health care system that leaves a seventh of Americans uncovered. Both numbers are rising. Two years from now, or 4, or 6, they will only be higher and harder to reverse. In the meantime, millions of people who could have been helped will still lack coverage. There will indeed be risks and costs if this Congress acts. It is important to remember that the cost will be enormous if it does nothing as well.

Mr. President, I ask unanimous consent that the entire editorial be printed in the RECORD at the conclusion of my statement.

The PRESIDENT pro tempore. Without objection, it is so ordered.

(See exhibit 1).

Mr. GLENN. Mr. President, reform is necessary to make sure that we do not price too many of our people out of business. If we do nothing, then we approach a catastrophe just a few years down the road. I do not think it is an option for us to do nothing. As these costs increase, fewer than 218 million Americans will have insurance; 37 million Americans will still be out there and their numbers will be added to. So doing nothing is not one of the options that we have.

How can we assure affordable health care to all Americans to the year 2000 and beyond into the next century? Well, we have a lot of systems proposed: Single payer; eliminate the insurance industry—basically, let the Government take it over—cover everyone; Government subsidies to 37 million Americans; a combined system covering certain areas; specific programs that would deal with the newborn or the elderly; an expansion of the Medicare system. All of these are things that have been considered in the past.

Mr. President, I would not propose that we dump our insurance-based system. I think we need to improve it. The President was criticized in his plan that he put forward because of some of the mandates and the requirements in that bill.

Let me digress just a moment to give the President some credit. The President seems to be a bit beleaguered lately. If we have health care reform in this country, it will be because we finally have a President who saw this as a requirement, saw the dangers of doing nothing, went at it, stuck with it and pushed and pushed. If his policy, if his program, if his proposal is not to be what is going to be enacted, then he still was for what we could get that was going to improve the system, because he believes in it—and I am convinced he believes in it, and Mrs. Clinton believes in it. She has worked on it. They believe in the future of this country and that the future of this country should have health care for all our citizens included. So the President has stuck with it. I have to give him credit for that. When we have health care reform, when we have health care for all one of these days, it will be in large measure because the President and Mrs. Clinton believed in it and they acted and they stuck to it.

We are proud of saying that every President since Harry Truman on up to the present time, with one or two exceptions, has proposed health care. But what have they done? They proposed it, and as soon as the political flak started, they backed off. I have to give this President a lot of credit for sticking with this.

We need reform. But what and how? We want to cover everyone. We want to have cost control. We want to have portability. We want to have coverage for preexisting conditions, which may come from some of the lack of prenatal care that I mentioned a moment ago. We have to figure out a way to pay for all of this.

What is full coverage? Is it 95 percent? That would certainly be a good step in the right direction because we are going downward now. I think only about 83 percent of people are covered now, and the coverage of our overall population has been going down instead of up.

We cannot have an absolute 100 percent. That is not going to happen. Just people coming across as illegal immigrants is going to ensure that we will never have 100 percent absolute coverage. Social Security, for all the years it has been in, is not 100 percent. So of all of this semantic argument about what full coverage is, what it is not, and whether we consider 95 percent to be full coverage, or 97 or 98, we know one thing—95 percent coverage would be a lot better than we are doing right now. So let us go for it.

We have different bills. They are very complex. They are all over the lot. We have different provisions. We have different coverage, different percentages, and different ways to pay for it. We stand here on the floor arguing about whether one bill is 1,400 pages or not. Another bill is trotted out, and we say it is great progress, this one is only 780 and some pages.

I think the American people are not going to be very much impressed with what size the bill is when it goes from 780 to 1,400 pages. We have bills proposed by a lot of people. We have bills proposed by Senator CHAFEE, Senator DANFORTH, Senator DOLE, Senator PACKWOOD, and Senator MITCHELL. All of these bills have a lot of merit in them, but they take different approaches.

I think the bill that Senator MITCHELL has put forward is an excellent compromise. It accommodates the views and the major concerns that were expressed earlier concerning health care reform. It takes a little different approach.

Some of the earlier proposals put the mandates up front. They were heavy. An 80–20 split on the cost between the employer and the employee. These were mandates, and they were up front as a forcing mechanism to say we are going to do it and do it now. There was a lot of objection to that.

All of the industry comes in. They come to our offices, and say, "Look. We are making a lot of progress. Why upset things right now because we are making a lot of progress? States are putting new plans into effect. We have new affiliations. We have new groups. There is a new awareness out there that the President has helped to spawn, and all this discussion has helped push it along. So why do we want to wreck things now? Let us do no harm to the system the way it is right now."

Let us go at this thing. There are affiliations. These things are actually happening. There is a lot of progress being made out there in the country with regard to health care reform.

What does Senator MITCHELL propose in his bill? He basically says he challenges these people to say, "OK. Let us go ahead. You are making progress. We realize that. It is not as fast as a lot of us would like, but we are making progress in these areas. Let us go ahead and do that kind of a job. Let us do it, and we will give you several years to accomplish this."

There is no mandate in the Mitchell bill. I repeat, there is no mandate in the Mitchell bill unless the industry fails, unless these objectives are not being met, unless the Congress refuses to act at that point and take other action. Only then is there a mandate. Then it is cut back to a 50–50 sharing. But only after industry has failed to improve the system enough, and only after Congress has failed to act. Only

then as a third order backup do we say that a mandate will cut in. Then it is only 50–50.

Even then it protects small businesses who cannot afford it, who might be put out of business. If they cannot afford it, it helps them out. It has a subsidy for them to help them out. In this whole process we do not dump the system that has built this health care system for the country. We do not dump the private insurance industry.

I think Senator MITCHELL has bent over backward to try to accommodate those who had legitimate concerns about some of the proposals that were being made. It keeps the private insurance system, and it builds on it. It is not sudden. It provides time for this to occur. It has been a long process. There have been hearings by the Labor and Human Resources Committee and the Finance Committee. The House has had hearings and has given a lot of consideration in this area. Think tanks have been done with innumerable studies in this particular area. It gives something to all of these areas. It picks the best of all of them. It is affordable. It guarantees high-quality care through our private health insurance system.

If it expands coverage, as the CBO says in their independent analysis, then there will be no mandate. If the 95-percent coverage is not achieved, then Congress can act on the advice of the monitoring commission that is set up to monitor what goes on during that period. They can make recommendations, and the Congress can act on those recommendations if we are not at 95 percent at the end of that period. If Congress has not acted, only then does this 50–50 mandate cut in as a last resort.

I think that is a reasonable approach. In fact, we have some people that say that it is too reasonable. They do not like the plan because it has gone too far.

Mr. President, we have heard a lot on the floor here the last few days about some of these new taxes—17 new taxes. I will not go through each one of them. That would take a couple of hours to go through and define each one of them. But on closer analysis, actually of those 17, you could say that 9 of those really are tax cuts. There are revenue increases in some of the others, such as a tax on tobacco products, and so on. But the 17, on close scrutiny, do not turn out to be the case.

Mr. President, we have a lot of doomsaying when something as big as this comes up. They say it is going to wreck the economy. It is always easy to say no. We can always find a reason to be against something. It is easier to tear down than it is to build up. It is easier to swing a wrecking ball at a building than it is to build that building.

We heard many of the same arguments against Social Security in its time, and we heard some of the same arguments against Medicare in its time, also. The health care doomsayers have had a field day with this. They have said it would wreck the economy, kill millions of jobs, and would cause taxes to rise on middle-class Americans.

That is what was said about the largest deficit reduction program in history that we enacted last summer. The doomsayers were out in full force on that one. The doomsayers said the plan would wreck the economy, kill millions of jobs, and cause taxes to rise on middle-class Americans. Yet, here we are one year later, and the economy is the brightest it has been in decades. According to Alan Greenspan, 4.1 million new jobs have been created during this administration. Income taxes have not been raised on the middle class. For the first time in a generation, Government deficits are going down, not up.

So for the doomsayers who are prodding out the old lines and charging that health care will wreck the economy, kill jobs, and raise taxes—well, I think the American people are smarter than we give them credit for. I do not think they are going to be scared to death by the buzz words of fear and obstructionism. They want health care reform, not delay. They want health care reform and not fear mongering and ramblings that have been discredited time and time again. The time to act is now.

So these same arguments were used in the old days against Social Security and Medicare. We got to speaking about Medicare, and I heard somebody in the cloakroom talk about receiving a phone call in their office about someone who was talking about—an elderly gentlemen, apparently, who said that Government programs are just bound to be bad, but "whatever you people in Washington do, do not mess around with my Medicare," as though that was somehow not part of a Government program.

I think this is a historic opportunity. I think it comes not even once every generation. I think it may come once every other generation. Costs are now at 15 percent of GNP, going up to 20 percent of GNP by the year 2003. Federal expenditures now of the total Federal budget are 17 percent on health matters, going up to 24 percent within 5 years by 1999. So one of our options is not to sit back and do nothing.

Mr. President, I deplore the political rancor that has gotten into this debate. If we started at the other end of the medical problem, if I go into an emergency room or you come with me to a hospital and I need treatment for something, you go in and the doctor asks you questions. Has the doctor ever asked anybody in that situation: Are you a Democrat or Republican? Before I treat you, I want to know whether you are a Democrat or a Republican.

If they did that, we would certainly think that was outrageous. That would be the worst thing you could be asked, to have a health problem and people arguing about whether you are a Democrat or Republican. Yet, the Senate is not being constructive in this matter, at our end of this, in providing a health care system. At the user end, it is not a Democrat and Republican issue; it is just a matter of health, and an individual's relationship to that health care system in getting treated.

Yet, we are not being constructive here. We are sometimes opposing just to oppose, no matter what. We find people getting up and saying they will oppose whatever comes up, no matter how good it is, or whatever the provisions are. They will use any means to defeat any proposals that are made, and they make that statement in public. It is quoted in the papers. To me, that is politics at its worst. That is not working together; that is not trying to work together to get health reform. Is health reform Republican? Is health reform Democratic? No, it is not. Whatever views are held, I hope that we can get together and say that we will start amendments, start votes, and we will go ahead with this. A good place to start, to me, is the Dodd amendment.

I hope we can have votes before the day is over today. Mr. President, I think this is so important and I think it is maybe once every other generation that we have something like health care reform come along—like Social Security did in its day and like civil rights did in its day, and so on—that is going to affect the lives of every single American into the indefinite future. We want to do it right. To those who say, "Let us not rush into this thing," I ask, let us not rush after 60 years of consideration? Let us not rush after piles and piles of studies and reports and committee hearings on this matter?

Now is the time to act. I hope we get on with it and vote before this day is over.

I yield the floor.

EXHIBIT 1

STILL TIME FOR HEALTH CARE?

The argument is now being made by a lot of people that Congress has let health reform go too late; that not even the authors know what is in the giant bills, some portions of which would likely be unworkable or do more harm than good; and that the problem, while important, isn't so urgent as to require risky action now when measured action can be taken later. In some respects the system may even be in the process of correcting its own defects. Better to wait and try to get it right, this critique goes.

Clearly, some of those taking this position are doing so for purely political reasons—just as some of the opposite pressure, that for hurrying up and passing a bill in the next two months, is political. But a heavy substantive argument can be made on behalf of delay as well, and most of the complaints have at least some basis, some merit. We continue to think, nevertheless, that there is

still time, though barely, to repair the problems and produce what would be a valuable bill and that Congress ought to try. The next Congress will be no better disposed to do a serious job, and may well be less disposed. It will probably be more sharply divided along partisan and ideological lines; it will be heading into a presidential election year; and, anyway, all Congresses are dilatory, so that it too will be unlikely to act until it is forced to do so by the prospect of adjournment, by which time this issue will be election fodder.

Meanwhile, the cost of health care continues to soar—and the higher it goes, the greater the number of people who lose insurance because neither they nor their employers nor the government can afford it. A seventh of all the money Americans have available to spend today goes into a health care system that leaves a seventh of Americans uncovered. Both numbers are rising. Two years from now, or four or six, they will only be higher and harder to reverse. In the meantime, millions of people who could have been helped will still lack coverage. There will indeed be risks and costs if this Congress acts. It is important to remember that the cost will be enormous if it does nothing as well.

The question is whether there is in prospect any kind of legislation that would significantly improve the situation without creating ominous new problems for either the economy or the health care delivery system itself. The answer has several parts. First: None of these bills is perfect; far from it. But some of their flaws are being greatly exaggerated. And, importantly: most could be fixed before enactment and in such a way as to justify enactment.

The bill that was put together by Senate Majority Leader George Mitchell, though certainly not itself without problems, does seem to offer the most promising framework for compromise. The measure was drafted in hopes of meeting a lot of the objections that continue to be leveled at it. The original Clinton administration bill was rightly criticized for laying far too heavy a federal hand on the health care system while pretending not to. It turned out to be, in fact, upon inspection, a flow-chart-gone-mad kind of health bill. This conclusion was reached not just by Republicans but by thoughtful members of both parties who felt the government should rely instead on the most modest combination of insurance market reform, government subsidies and government-structured competition to achieve its goals of broader coverage and cost containment. Mr. Mitchell attempted to meet these objections. However, some prospective supporters believe that he did not go far enough. Are the differences negotiable? We believe so. Is there more potential agreement in the conflicting positions than meets the eye? We believe that is true as well.

To take an example, consider the argument in favor of delay made on the op-ed page the other day by the respected columnist Robert J. Samuelson. Mr. Samuelson began by noting that "the Democratic health care plan," meaning the Mitchell bill, "contains a large—and unjustified—multibillion-dollar tax on younger workers" which he doubted most members of Congress even knew about. The "tax," however, turned out to be a staple of insurance market reform that is in not just the Democratic health care plan but practically every plan—including Bob Dole's. The problem it seeks to address is that too many insurers "cherry-pick." They try to sell separate, low-cost policies to the healthy, including the young. The effect is to relegate higher-risk buyers to costlier pools; the people who need insurance the most are left least able to afford it. Market reform seeks to spread the risk and cost instead across a broader pool, in part through so-called community rating: Everyone in a community pays, if not the same for a given policy, at least closer to the same than now.

The debate is about how far to go in this regard. The Mitchell bill would continue to allow some rate variation according to age; the Dole bill would allow more; but both would limit current practice on grounds of equity and in hopes of making insurance more accessible. That's the tax. It is one of the (many) constructive principles on which, beneath the rhetoric, Congress appears to agree—and one of those that leads us to believe that with good-faith negotiation a useful bill could still be passed.

Mr. HATCH addressed the Chair.

The PRESIDING OFFICER. The Senator from Utah is recognized.

Mr. HATCH. Mr. President, I appreciate the comments of the distinguished Senator from Ohio, and all who have spoken thus far. I personally pay tribute to Mrs. Clinton in the efforts she has put forward in trying to come up with something that would help solve what many think is a health care crisis in our country. One of the problems, of course, is who is going to pay for all this? All of us want to solve this problem. All of us want what is called universal coverage, which is defined in various terms and in various ways.

All of us would like to make sure everybody has coverage. We would all like to stop the cost shifting onto certain segments of our society. But it comes down to who is going to pay for it? Anybody who believes that by having a huge, additional Federal Government program on top of everything else that we have today is going to solve these problems and reduce costs, they just do not know what they are talking about.

Why are we all here? We are here because we want to help people. We want to help people who are not receiving the health care coverage that they need and deserve. We are here because of admirable citizens like Helen Roth of Utah, who came to my office and implored the Congress to make sure that the disabled receive the care to which they are entitled. We are here because of two articulate teens, Ryan Van Dyke of Brigham City, UT, and Jason Brown of West Valley City, UT, both diabetics who are struggling to get the care they need. We are here because of Travis Carlson, born blind and deaf, whose parents have struggled to get him the care he needs. We are here to help these people, not hurt them.

When this debate opened, the distinguished majority leader took to the floor and made a very eloquent statement. He talked about the need for a bill. He said that providing health insurance to all Americans "was a matter of simple justice."

Yet, the Clinton-Mitchell health care reform bill is not simple justice. There is nothing simple about this bill—nothing. It is complex. I want to talk about the justice in this bill. Is it justice to take almost $200 billion out of the Medicare Program, severely jeopardizing its future? Is it justice to cut Medicare on the one hand and then propose to expand it with new programs such as a prescription drug benefit which may help only a very few?

Is it justice to impose 18 new taxes on our people?

As I walked over to the Capitol this afternoon, I thought back to all the conversations I have had with my constituents who are so interested in health care reform.

I have had a chance to meet with people from all walks of life to discuss every conceivable aspect of health care reform.

It has been reported that the so-called special interests are lobbying Capitol Hill on this issue.

The fact is, on health care reform, every person in America is a special interest.

Each and every American is a special interest, and rightfully so—we all have so much at stake.

My own feelings about this legislation have been shaped by the many conversations I have had with the citizens of Utah. And I will say, in all candor, I have learned a lot from them.

I have learned that the people of Utah care about health security for their fellow citizens. When a health crisis strikes a family member or friend, all of us want to know that the best possible care will be given to that individual.

The people of Utah care about quality. They know that our Nation leads the world in technological advancements in medical science. The University of Utah Medical Center in Salt Lake City is one of the preeminent centers in the world for innovations in the treatment of such complex medical conditions as heart disease and cancer, as well as being one of the world leaders in genetic research.

The people of Utah also care about choice. They believe that all Americans should continue to have the freedom to select the medical care that best meets their individual needs. They know all to well that the role of Government has a finite place in the larger scheme of health care delivery.

The people of Utah sent me to the Senate as their representative to make decisions that benefit all the people. And as my colleagues know all too well, there are no easy solutions to the complex issues addressed in reforming health care.

This legislation will ultimately impact the lives of every man, woman, and child in our great country. No one will be spared. The practical implications of this bill are simply staggering--one-seventh of the U.S. economy is going to be restructured. If the

Mitchell bill passes, it will be one-fifth of the GDP, by the year 2000 or shortly after. It is nearly $1.2 trillion.

Its impact would likely be felt for generations to come—well into the next millennium.

The bill has been described as the most significant piece of legislation since the establishment of the Social Security Act. Some say that it may be the most important piece of legislation considered in this century.

Indeed, we should not underestimate the magnitude of the task before us. It has been an extraordinary endeavor. In spite of what ultimately happens in the next several weeks, I believe that the American people have benefited from the enormous amount of time and energy Congress has devoted in examining our health care system.

As a member of the Labor and Human Resources Committee, the Finance Committee, and the Judiciary Committee, I have had a unique opportunity to be involved in the development of health care reform legislation. Each of these committees played a major role in developing the various proposals that have not brought us to this moment on the Senate floor.

As my colleagues, particularly those on the Labor and Human Resources and Finance Committees know all too well, this has not been an easy process by any stretch of the imagination.

The Labor and Human Resources Committee held 46 days of full committee hearings over the past year and heard the testimony of countless witnesses. We held hearings on issues ranging from the consolidation of the 19 different Federal core functions of the public health programs, to the issue of creating new categorical grant programs aimed at addressing the needs of medically underserved populations—an issue, I might add, that is of critical importance to Utah.

We focused on the merits of a standard Federal benefits package as well as the categories of provider services covered in a benefits package. We focused on the methodology that would be needed to determine how those services would be included in such a package.

On June 9, 1994, after nearly 3 weeks of marathon markup sessions that began on May 18, the Labor Committee reported the Clinton-Kennedy Health Security Act by a vote of 11 to 6.

I was one of the six Senators who voted against reporting the bill. It was unfortunate that the Democrats on the committee, who comprise a majority, repeatedly rejected amendments to lessen the regulatory and bureaucratic grasp this legislation would have on America's health care system.

Following the action by the Labor Committee, the Finance Committee began its markup of another version of the Clinton bill. There was considerable expectation and hope that a bill with fewer Government controls, fewer Government mandates, and fewer taxes would be adopted.

The Finance Committee held 36 days of hearings and heard from 143 witnesses representing all aspects of health care.

We heard about the imposition of Government mandates on individuals and businesses, about the effects of so-called global budgets on the delivery of health care, about cuts in the Medicare and Medicaid Programs, on insurance reforms and the effects of guaranteed issue and renewability, as well as limits on preexisting condition exclusions.

We heard about quality from the Nation's leading health care quality scholar, Dr. Brent James.

We heard about the establishment of low-income subsidies for individuals and families; about cost-containment including the imposition of taxes on individuals, on companies, on insurance premiums, and on guns, bullets, and tobacco.

On July 2, 1994, the Finance Committee reported its version of the Clinton health care bill by a vote of 12 to 8. And, once again, the same kind of Government-run approach to reform, as proposed by President Clinton, was embodied in the legislation as reported by the Finance Committee. The prospect for meaningful reform was, once again, thwarted.

I believe that true reform should rely less on Government control and more on economic incentives that leave health care decisions in the hands of individuals, and not with someone in Washington, DC.

We should address the problems in the system and fix what is broken. We should not overhaul the entire system in the name of reform. To do so will jeopardize the standard of excellence which is the hallmark of American health care.

The distinguished Senator from Ohio said there are some who are saying "no," they are naysayers; they do not want anything. I do not know of anybody on the floor in the Senate right now who is saying "no." Everybody agrees we need to do something to help the 14 percent who do not currently have health insurance. The question is, how do you do it with more Government, with more governmental programs, with more Government approaches, more mandates, more controls over the States, and less incentives for free market reform? That is what these bills do. Yet none of the bills reported by the House and Senate committees, as liberal as they are, went far enough for the President and the First Lady, I might add. And so, we find ourselves on this day in August not with a bill reported by the Finance or Labor Committees, but with an entirely new piece of legislation which is only days old.

This is a brand new bill, a melding, if you will, or attempt to meld from the Labor and Human Resources Committee and the Finance Committee what they had done.

The latest version of this bill is 1,443 pages long—79 pages longer than President Clinton's original legislation. And yet, we are being forced to make decisions, of historic importance, with as little as 1 week in which to analyze the bill's full implication and costs ramifications.

This is not how the legislative process should work. It is the legislative process at its worst. The manner in which this bill has been hurriedly drafted and presented to the American people, and to the U.S. Congress, has been more out of the need for political expediency by the President, than by a need for reform. In a very real sense, our actions may serve to irreparably damage the viability and integrity of the world's preeminent health care system which the proponents of this bill claim to be reforming.

I would remind my colleagues, it was not by government intervention that the health care system of the United States became the finest in the world. It is the world's finest because the system has evolved in an environment relatively free from excessive government control and social engineering.

I do not subscribe to the proposition that a Federal takeover of health care is what the American people want. I am fearful that the shouts for reform by the President and his lieutenants in the Congress will drown-out reason and prudence in addressing the real problems of our health care system.

The Clinton-Mitchell bill is fundamentally flawed. It will unravel the very fabric of health care as we know it, and by then it will be too late to correct the damage we have done.

Make no mistake about it, the Clinton-Mitchell bill is health care reform. But I can assure you, it is not the kind of reform that the American people need, or want.

This bill contains sweeping and contentious provisions. Many of the key elements were cobbled together at the last minute during hurried committee markup sessions and are barely understood even by their sponsors—let alone the American people.

The distinguished majority leader has stated that his bill is nothing new. He said his bill encompasses many of the same provisions in other bills as reported from the Finance, and Labor and Human Resources Committees. Well, when I see the Mitchell bill, the Gephardt bill, the single-payor bill, and all the others which seem to be coming down the pike daily, I am reminded of that old saying: "It's sad when cousins marry."

The Clinton-Mitchell bill proposes to expand health care coverage to millions more Americans which is a goal I certainly share. But the bill's prescription for health care reform includes

massive doses of new taxes as well as new levels of spending and government intrusion which I believe most Americans will find totally unacceptable.

The bill imposes at least 18 new taxes, including a tax on health insurance premiums. These 18 new taxes will hit health insurance plans, flexible spending accounts, Medicare beneficiaries, and State and local government workers with hundreds of millions of dollars in new taxes.

And who do you suppose is ultimately going to bear the burden of this tax? I will tell you: It is going to be the person who cannot pass the cost increase on to anyone else—health care consumers and employees all over America.

This bill contains what amounts to price controls on health insurance. The bill imposes several taxes on health insurance premiums, including a complicated levy on plans whose premiums grow at rates faster than the government prescribes.

The Clinton-Mitchell bill bans self-insurance for companies with fewer than 500 employees. Self-insurance is a classic success story of how companies control health care expenditures. This is working for an estimated 21 million employees and their dependents at over 400,000 small- and medium-size companies throughout America.

These beneficiaries are very happy with their current insurance arrangements. Yet, under the Mitchell bill, all of those plans will be terminated, and these individuals will be forced to purchase their health care through government sponsored health alliances that will establish a one-size-fits-all benefits plan.

If we have programs like self-insurance that are successfully controlling health care costs, and serving to expand health care coverage to more Americans, then I simply cannot understand the logic in not allowing these programs to continue. And I can assure my colleagues on the other side, that once these plans are terminated, you will certainly be hearing from those individuals.

I received a fax just last week from the Seniors Coalition expressing their concern over this legislation. They are concerned about the Medicare cuts in the Mitchell bill, as am I. The sponsors say these cuts are only in reimbursements to providers and not in benefits. As the fax for this organization clearly points out:

Reducing reimbursements to doctors and hospitals will lead to a simultaneous degradation in the quality and quantity of care to Medicare patients which will exacerbate the cost-shifting problems already caused by Medicare.

We all know doctors are refusing to take Medicare patients because of their low reimbursement rates and that is going to get worse if this bill passes. And the Medicare recipients will be the ones hurt.

These are just a few examples of the so-called reforms, showing the pay-more-get-less effect of this legislation.

I hope all Americans become familiar with the other provisions contained in this massive piece of legislation, which has been crafted in the name of reform.

As I stand here today on the Senate floor, I can look up to the gallery where I see hundreds of people observing these proceedings. Most of them are visitors from across America.

And, like many Americans during these long, hot days of August, they are spending more time with family and friends, and taking some time off from otherwise hectic daily schedules.

Millions of other Americans are watching these proceedings on television. All of us are united in our concern over the outcome of this historic debate.

But I can assure you that the crescendo of public concern over health care reform has not waned during this traditional time for family vacations. Thousands of letters from citizens in my State and from across the country continue to pour in.

The overwhelming message is for reform, but against a Clinton-like structure as embodied in the legislation before us today. There is also overwhelming support, nearly 64 percent in recent public opinion polls, for Congress to take a careful and deliberate course of action that will not harm our current system.

I have been impressed with both the number and substance of the letters I have received on the issue of health care reform. Some have been very direct and short. Other letters have afforded me with an opportunity to learn first-hand the thoughts and feelings of people who have truly been affected by the strengths, and weaknesses, of our health care system.

One such letter in that category was from Rodney Ririe of Provo, UT. He is a young man with many hopes and ambitions. He is not unlike any one of us in this Chamber. Yet, his life has been filled with the kind of pain only few people can imagine and, indeed, most of us fear.

On June 10, 1994, he wrote to me regarding his views on health care reform. It was a five page letter—typed—and single-spaced. I am not going to read the entire letter. But I am compelled to share an excerpt with my colleagues in the Senate.

I do not ask that you agree or disagree with what he says. I only ask that you listen to what he says.

He writes:

I am writing with regard to some serious concerns related to health care issues that currently face our Government. Before proceeding, however, let me give you a brief idea of my background, so that perhaps you might better understand where I come from.

Currently, I am a college student attending Brigham Young University, where I have been for the past five years. Part of the reason I have not yet graduated is because of my health. You see, when I was five years old, I suffered a near-fatal heart attack.

Before that time, doctors thought of me as a normal, healthy five-year-old child. Doctors diagnosed me as having a form of "cardiomyopathy" or disease of the heart which affects the development of the muscle walls. Four years later, I had another heart attack, three more at age eleven, and two at age twelve—a total of seven heart attacks in my brief life.

He continues:

At age 17, I underwent a heart transplant operation. Since that time, I have been mostly healthy until about a year ago. Doctors have recently discovered that I am suffering from a form of coronary artery disease commonly found in transplant recipients, for which they say I will need a second transplant within the next several months.

As you can imagine, paying for these things has been a burden on my parents and family. Fortunately, we have had good insurance in the past, but with my pre-existing condition, premiums have been all but inexpensive, and in an effort to keep the premiums as low as possible, we chase higher deductibles. My father will retire in two years (at age 68) a poor man, devoting nearly all his savings to help pay for my care.

In May of 1995, I will turn 26 years old which will disqualify me as a dependent on my parent's insurance policy. With my current medical expenses costing between $40,000 and $60,000 a year, the onslaught of another transplant, and the fact that no insurance company in the country will pick me up, this places the entire financial burden on me, a part-time college student who works in part-time job making $5.90 an hour.

Finally, at the end of his letter, he states:

With this background in mind, I write you not seeking sympathy of any kind, but rather to express my heart-felt opinion on the subject of health care. From one who has experienced so much, you might expect this letter to be from one in favor of President Clinton's health care proposal. In fact, there could not possible be a greater opponent of this plan.

It's sad, but in the past when my government has made a decision I disagreed with, I passively did nothing, thinking that the decision would not really inconvenience me, or affect me directly except for having to pay a few more dollars in taxes. But with this issue, I cannot be silent.

I oppose the plan for several reasons—many of them personal—but most of them out of simple common sense. For as long as I can remember, the United States has always been on the cutting edge of the latest advances in medicine. Truly, had I not been born and raised in this country with the problems I have had, I know I would not be sitting here now.

With the plan Mr. Clinton proposes, I feel strongly that with a lack of research funds, the U.S. will quickly fall from its prestigious place in the world of medicine. The plan does not yet acknowledge how to pay for itself, let alone further research in health care.

The PRESIDENT pro tempore. The Chair will interrupt the Senator to say that, unless the time is extended by unanimous consent, there is an order for recessing the Senate after this hour.

Mr. HATCH. Mr. President, I ask unanimous consent through the Chair,

then, that we be granted another 10 minutes.

The PRESIDENT pro tempore. Would the Senator speak just a bit louder, please?

Mr. HATCH. I ask for another 10 minutes by unanimous consent.

The PRESIDENT pro tempore. Is there objection?

Mr. DORGAN. Reserving the right to object and I shall not object, I wonder if the Senator from Utah would do me the courtesy, as he extends his time, including in his unanimous consent, that I be recognized to speak when the Senate reconvenes at 2:15?

Mr. HATCH. I apologize, but we do have an objection here because there have been three speakers over there to one over here. I have no personal problem.

Mr. MOYNIHAN. No, no, there have been two. We are alternating as we can.

Let me make the request. We are alternating.

Mr. HATCH. I think the Senator ought to be able to speak at 2:15, then maybe we can go to a Republican after that.

Mr. MOYNIHAN. Sure.

The PRESIDENT pro tempore. Unless the Chair be misunderstood, there is no order for alternating.

Mr. MOYNIHAN. Yes.

Mr. HATCH. We have been following that.

Mr. MOYNIHAN. Mr. President, would it be in order for me to ask unanimous consent that at the conclusion of our recess for the caucuses that Senator DORGAN be recognized?

The PRESIDENT pro tempore. It would be in order.

Mr. COATS. Reserving the right to object, and I am not going to object either, I just want to make note of the fact that yesterday evening, the majority leader——

The PRESIDENT pro tempore. Let the Chair interrupt the Senator. The first request is before the Senate and has not been acted upon; that request being that the time at this point be extended 10 minutes. Is there objection? The Chair hears no objection. The Senator from Utah is recognized for 10 minutes.

Now, the second request, if the Senator from Utah will yield for that purpose.

Mr. HATCH. I do yield for that purpose.

The PRESIDENT pro tempore. The second request is that Mr. DORGAN be recognized upon the reconvening of the Senate, following the recess, at 2:15 p.m. today. Is there objection? The Chair hears no objection, and it is so ordered.

The Senator from Utah is recognized.

Mr. COATS. Will the Senator from Utah yield for 30 seconds?

Mr. HATCH. Sure.

Mr. COATS. Mr. President, I thank the Senator from Utah. I want to make the point that last evening the majority leader said on a number of occasions that Republicans were filibustering the bill, and yet we seem to be proceeding here in the same way we proceeded for the last several days, and that is, we have been alternating between Republicans and Democrats who wish to speak on the bill, who are doing that again today.

The Senator from North Dakota has asked for time, as have several of his colleagues today. The Republicans have granted that. We are all trying to understand this bill which has immense implications for the people of this country. I do not see any semblance of what was described last evening as a Republican filibuster. I thank the Senator from Utah.

Mr. HATCH. Mr. President, I have been reading from a letter of this young man, who has had seven heart attacks and now is facing a second transplant, as to why he opposes the Clinton health care program. You would think that he would not.

Let me continue.

He further states:

> Senator, I cannot emphasize enough how extremely important this issue is to me. It is important for me and for many others, I'm sure, to be able to choose the doctors they want to see and to be assured the same quality health care they've been expecting and received for so long. I honestly fear the passage of this bill; I know it is not the answer, and I hope you do to.

This is a young man who has gone through so much all of his life and, to be honest with you, I was very touched by his letter.

Mr. President, I ask unanimous consent that his full letter be printed at the conclusion of my formal remarks in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mr. HATCH. Mr. President, as Rodney clearly and so eloquently states, this issue is just too important for "politics as usual." As Rodney Ririe further states at the end of his letter, "I pray you will remember why I sent you to Washington—to represent me not the President."

For Rodney Ririe, and many others like him, we can act and correct the fundamental problems with the system.

For instance, most of us agree that we need insurance market reform. On this one issue, there is almost unanimous support to provide for guaranteed issue of all health insurance plans regardless of the individual's health status, or other risk factors.

We need to ensure portability so that persons do not lose their insurance if they change jobs or are faced with unemployment. These few steps along would lead to greater health care coverage for millions of more Americans.

Another area of reform concerns medical malpractice and antitrust reform. Both of these issues involve costly regulation of the health care market which, in turn, serves to drive up the costs of health care services for all of us.

Unlike most regulation, though, the regulation in these areas is left largely to the courts where decisionmaking is incremental, often unpredictable, and always expensive. The results are often inconsistent, and not just across jurisdiction.

There is widespread agreement on the need to reform our medical malpractice laws. The estimated 1991 costs of defensive medicine range from $4 to $25 billion according to the National Medical Liability Reform Coalition. More recent estimates place this year's impact at close to $30 billion.

Medical liability premiums contributed an estimated $9.2 billion to the cost of health care in 1991. What is more staggering is that only 43 percent of each dollar spent on liability litigation reaches the patients; the rest is spent on so-called overhead, such as attorneys' fees.

And yet, the medical malpractice provisions in the Clinton-Mitchell bill have rightly been called the Mitchell Trial Lawyer's Full Employment Act. This bill creates, at least 15 new Federal causes of action and 7 new Federal crimes.

In addition, the bill as drafted proposes to undo any reforms that have been achieved in the States while imposing new costs on the litigation system. These so-called "reforms" will, in effect, hurt malpractice victims as well as all patients, by driving up the costs of health care, and escalating liability litigation.

Antitrust works in the same way and has the same problems as the malpractice system. The antitrust laws are intended to ensure that markets are free to function in their most efficient ways. But make no mistake, antitrust is regulation. Too much antitrust enforcement is just as dangerous to health markets as too little.

Antitrust is a complicated area of the law, and violations carry large penalties. Antitrust counsel is expensive, and antitrust litigation costs can be crippling to small entities. Providers, especially small and rural providers, are very concerned about the dangers of antitrust litigation.

As we consider massive restructuring of the health care market, we need to reduce antitrust uncertainty that will, undoubtedly, be exacerbated by reform.

We are all aware of the problems. At the hearings in the Finance Committee earlier this year, Senators MITCHELL, BAUCUS, and ROCKEFELLER pointed out the real concerns of rural providers in their States. Senator CHAFEE expressed to witnesses from the Federal Trade Commission about the frustrations providers feel.

For example, if two rural hospitals decided to discuss the mutual allocation of special services in order to

achieve some economies of scale, they could be liable to an antitrust challenge simply because they had established a possible conduit for sharing price and billing information.

Many other providers face the same kinds of risks if they wish to come together to compete with other groups. Home health care providers, nurses, and nurse anesthetists all equally face the challenges of a changing market in which competition itself will force greater consolidation.

Small groups of rural providers—in fact any small group—simply cannot be expected to hire expensive antitrust attorneys to review and approve every cost-containment option considered. I believe it is in our best interests to see health care providers improve their efficiency by allowing them to eliminate duplicative services.

In my home State of Utah, two hospitals had to spend over $7 million to prove to the Justice Department that their world-renowned work in pediatrics helped patients—and not harmed them. We have seen millions of dollars—including millions of taxpayer dollars—spent on expensive antitrust litigation. These dollars should have gone toward patient care. Whatever the outcome, the process is too costly and we need to do something about it now.

I think what I am trying to say is this: That we could do a reasonable reform of the health insurance system of this country that will solve most of the problems that we have and get the universal access well above 90 percent and possibly as high as 95 percent. I remember about 3 or 4 months ago, maybe 5 months ago, Roger Altman came to me and met with me in my office. The first words out of his mouth were: "Senator, we know our bill is not going to pass." They knew it then.

But he said one thing: "We have to have 'universal coverage.'" And I mentioned to him, universal coverage happens to be a set of relative terms. He acknowledged that. I said the last 5 percent is so expensive to cover that it is almost impossible to have total universal coverage, and he acknowledged that.

And then I said, "If we would reform the insurance system in this country and make insurance portable, noncancelables, except for fraud or failure to pay, so that we take care of preexisting conditions, we would resolve most of the problems our society has and we would please well over 90 percent of the people in our society and make insurance available to them."

I said that would be a big win for the President, we would all support him, we would get it done, it would be a step toward universal coverage that you probably are not going to be otherwise able to make.

And he looked wistfully at me as though "I wish we could do that."

The fact of the matter is, the reason why we have this huge, massive, convoluted piece of legislation that nobody here fully understands and, frankly, is an amalgamation—and a poor one at that—of a variety of plans, is because those who are for that basically want to be able to make the claim that they are taking care of every man, woman and child in America. In fact, they know they are being taken care of now and that we can do a better job of providing care without bankrupting the country or turning all health care over to a one-size-fits-all Federal health care system. Anybody who believes that approach is going to save money really, really does not understand the last 60 years. Anybody who believes that is going to bring health care costs down, is not thinking. And anybody who believes that will make a better health care system than we have today with the partnership between Government and the private sector, I think is loco, to be honest with you.

Another issue that has attracted widespread support is in the area of enhancing our network of community health centers. The Federal costs of community health centers are estimated to be around $100 per patient per year. It seems to me that we should expand the role of these centers to provide needed care to underserved areas of the country.

As we address the issues of rural health care we should be guided by a simple formula developed by Pamela Atkinson, a vice president at Intermountain Health Care in Utah. Ms. Atkinson is an expert on rural health care. She advises me that the problems associated with the delivery of quality health care in rural America must be guided by the four A's.

They are: affordability, accessibility, availability, and awareness.

We need affordable and accessible services in rural and in urban areas. And, we need available services that include providers, facilities, and the equipment to provide services in a culturally sensitive manner.

It is the awareness issue, however, that has not been discussed much. Pamela informed me that there are normally 950 visits scheduled a month in Intermountain Health Care's community health centers. However, between 150 to 200 patients never show up for their scheduled visits. They just do not understand the importance of early diagnosis and treatment.

I do not know if my other colleagues have heard similar statistics, but I was surprised to learn the extent of this problem. This is especially troubling when you recognize that we are talking about scheduled visits, with so many more individuals who never make the effort to visit in the first place, and who, therefore, never receive needed care.

Obviously, we need to improve health services in these areas by increasing awareness in the community and emphasizing health promotion, health prevention, and early detection.

I would also like to comment about the proposed legislation that has been developed by the distinguished Republican leader, Senator DOLE. I strongly support the Republican leaders' bill. It has many important features that go a long way in addressing the needs of those Americans without health insurance.

The bill provides for positive insurance reforms so that people would not have their insurance canceled or their premiums increased because they got sick or lost their job. Individuals would be able to obtain insurance regardless of their medical condition.

The legislation contains many important incentives to control the costs of health care and ensure that all Americans have access to quality and affordable care.

The bill provides for medical savings accounts so that individuals would have greater control over the expenditure of their health care dollars. Third-party insurance would cover catastrophic expenses.

The bill provides for tax fairness so that people who purchase their own insurance would receive the same tax relief as those who obtain insurance through an employer.

Self-insurance by small- and medium-size employers would be permitted to continue. This has become one of the most cost-effective mechanisms employers use to control health care costs. The Dole bill allows that to continue; the Mitchell bill does not.

Overall, Senator DOLE's legislation offers a commonsense solution to the Nation's health care problems. The bill provides health security to the middle class through insurance and market reforms while expanding coverage to low-income and middle-class Americans.

It accomplishes these goals without increased taxes, without expanded bureaucracies, without spending limits imposed by global budgets and price controls, and without employer mandates that ultimately lead to wage and job reductions.

The bill does not contain Government mandates on employers, or individuals, that would require them to purchase insurance whether they want to or not.

There are no mandatory Government health alliances that give Federal and State control over the insurance marketplace.

There are no Federal price controls or global budgets that inevitably will lead to health care rationing, particularly for those most in need.

Mr. President, I look forward to the debate, and I call on all Americans to listen carefully. Your future is at stake.

For the sake of the country, I hope our actions will be guided by the wisdom to do what is right, not what is expedient.

I yield the floor.

EXHIBIT 1

RODNEY E. RIRIE,
Provo, UT, June 10, 1994.

Senator ORRIN G. HATCH,
U.S. Senate, Washington, DC.

DEAR SENATOR: I am writing with regard to some serious concerns which I have related to health care issues that currently face our government. Before proceding, however, let me give you a brief idea of my background, so that perhaps you might better understand where I come from.

Currently, I am a college student attending Brigham Young University, where I have been for the past five years. Part of the reason I have not yet graduated is because of my health. You see, when I was five years old, I suffered a near-fatal heart attack. Before that time, doctors thought me to be a normal, healthy five-year-old child. Doctors diagnosed me as having a form of cardiomyopathy, or disease of the heart which affects the development of the muscle walls. Four years later, I had another heart attack, three more at age eleven and two at age twelve—a total of seven heart attacks in my brief life. Shortly thereafter I became a candidate for a new form of technology known as an Automatic Implantable Cardiac Defibrillator (AICD), and had surgery to implant the experimental device, which I carried inside me for more than five years. At age 14, I suffered a stroke which completely paralyzed my left side for several weeks. And, finally at the age of 17, I underwent a heart transplant operation. Since that time, I have been mostly healthy until about a year ago. Doctors have recently discovered that I am suffering from a form of atherosclerosis (coronary artery disease) commonly found in transplant recipients, for which they said I will need a second transplant within the next several months.

As you can imagine, paying for these things has been a burden on my parents and family. Fortunately, we have had good insurance in the past, but with my pre-existing conditions, premiums have been all but inexpensive, and in an effort to keep the premiums as low as possible, we chose higher deductibles. I am blessed to have had a father who practices dentistry in my home state of California, that we have had the means to pay for these expenses. However, bills were not paid without sacrifice. My father will retire in two years (at age 68) a poor man, devoting nearly all of his savings to help pay for my care.

In May of 1995, I will turn 26 years old which will disqualify me as a dependent on my parent's insurance policy. With my current medical expenses costing between $40,000 and $60,000 a year ($10,000/year for medication alone), the onslaught of another transplant, and the fact that no insurance company in the country will pick me up, this places the entire financial burden on me, a part-time college student who works a part-time job making $5.90/hr.

With this background in mind, I write you not seeking sympathy of any kind, but rather to express my heart-felt opinion on the subject of health care. From one who has experienced so much, having seen the inside of literally scores of different hospitals, and observing (and participating in) the system for so long, you might expect this letter to be from one in favor of President Clinton's health care proposal. In fact, there couldn't possibly be a greater opponent of this plan. It's sad, but in the past when my government has made a decision I disagreed with, I passively did nothing, thinking that the decision wouldn't really inconvenience me, or affect me directly except for having to pay a few more dollars in taxes. But with this issue, I cannot be silent. It is also sad that such an issue has become so politically polluted, becoming nothing more than a Washington boxing match between the isles of Congress. Health care—people's lives—are not to be used as pawns for a political battle for power on Capitol Hill.

I oppose the plan for several reasons—many of them personal—but most of them out of simple common sense. For as long as I can remember, the United States has always been on the cutting edge of the latest advances in medicine. Truly, had I not been born and raised in this country with the problems I have had, I know I would not be sitting here now. With the plan Mr. Clinton proposes, I feel strongly that with a lack of research funds, the United States will quickly fall from its prestigious place in the world of medicine. Evidences of this are everywhere. The plan does not yet acknowledge how to pay for itself yet, let alone further research in health care.

The plan boasts "security" by "providing every American with comprehensive health benefits." This obviously means everyone is guaranteed coverage whether one can pay for it or not. I fear there will be many who will take the attitude that "if I'm going to be covered no matter what, then why pay for it at all? After all, it's guaranteed."

Not only will there be a flagrant misuse of the system, but it will bankrupt many small business owners as well. Businesses large and small will find the burden of paying for employees' health care overwhelming, and will opt for layoffs over benefits. From what I understand, the Clinton's conservative estimate on unemployment will be "minimal"—perhaps only 600,000 people will lose their jobs. Recently, my father returned from a meeting with his accountant where the topic was the governmental health care system. The accountant admitted that he didn't have all of the information available, but with the estimates had at that time, he forecast costs in the neighborhood of $400 per month per employee. With my father's small business of only eight employees, that figure translates to a whopping $38,000 per year—enough to seriously damage my father's business, forcing him to not only lay off competent employees, but also raise his dental fees, which many complain are too high now.

And what happens when we do run out of the amount budgeted for the health-care year? Do we begin rationing care by closing hospitals and denying citizens the care we promised them? I read an article recently from a Toronto newspaper (sent to me by a friend) that reported the Canadian government was running low on funds for their health care program, and that to remedy the situation, they were not only rationing care (postponing badly needed treatments), but closing hospitals—denying their citizens the care promised and paid for. A recent article in the March 1994 Reader's Digest confirms this and further informs readers that the Clinton bill "specifies heavy criminal penalties (fines, seizures of property, long prison terms) for 'bribery and graft in connection of health care.'" Surely, if they are anticipating bribes, they must also undoubtedly be anticipating shortages and rationing. Why else would they impose such stiff penalties?

Besides the monetary aspect, there are the new bureaucracies that will undoubtedly be formed. Some conservative estimates place the number at 105 new government entities with a minimum of 50,000 new public employees to further enlarge our already over-sized government. If this is true, then the plan promises to be nothing more than another agency of red-tape, long lines, and bureaucratic mumbo-jumbo. This country needs less government * * * NOT more.

Basic economic principles tell us that nearly every time you take something away from the government and give it to the private sector to operate, free enterprise prevails offering individuals a greater quality of a product or service, better prices, and the choices we Americans demand. If this plan goes through, the opposite will no doubt take effect. The choices will be severely limited (regardless of what they say—the plan basically spells it out). The prices may be controlled (lowered) by the government, but with all of the governmental agencies, alliances, paperwork, and other inefficiencies the government has shown throughout the years, the overall costs can't help but be more than what they are today. And, I believe, and this is the main point I wish to stress in this letter—the one point I feel more concern for over any other—the quality of care will drastically decline.

Under the managed care (or HMO) system proposed by the President's plan, patients' choices will be minimal and the care itself will deteriorate. In a traditional managed care system, doctors are paid a flat rate for each patient they see each month. Therefore, they have no incentive to see the same patient, sick as he may be, more than once a month. Surely this keeps costs down, but who really comes out ahead? Under similar plans in California, doctors hired by HMOs are paid a flat salary, regardless of the number of patients they see, or the number of procedures they perform. With this way of thinking, doctors could easily adopt a careless attitude, reasoning that they can give quality work, or "shoddy" work, and either way, they still get the same pay. Essentially they are worry free when the employer pays all their malpractice and other expenses. I feel strongly that while HMOs do save money in preventative care and other budget-cutting programs, the quality of care is severely compromised, and care is what health care is all about.

To illustrate this point: My roommate recently had two visitors from Great Britain. Being their first time in the United States, they had many questions about government, etc. and were especially interested in the direction the country was heading with the health care issue. We discussed this at length and they explained that in Britain, people have the choice of private or government health care providers. Ironically, one of the visitors had frequently chosen the government form of care to save money, and the other had chosen private. As they spoke, it became very evident that the visitor who had the private providers, was much more satisfied, and had had quality care, while the other spoke of long lines, poor care (her dental work was visibly bad), and a genuine lack of personalized service and caring that we are so accustomed to as Americans. Again and again she told us how fortunate we were to have a private system of health care.

Senator, I cannot emphasize enough how extremely important this issue is to me. I have seen hundreds of doctors in my lifetime. Each time I find one I'm not satisfied with, I have the option of going to another. Obviously, we as Americans want the best possible care available. And if doctors have no incentive to work harder, or to go the extra mile, to "produce the best possible product," the care itself can't help but become compromised.

I have a doctor I see every six or eight months for a procedure known as a biopsy, where small pieces of heart tissue are pulled out through a vein in my neck to be analyzed for possible rejection. The procedure takes only 10-15 minutes, and is fairly uncomfortable. Over the past seven years I have had my new heart, I have watched the doctor's fee for this procedure rise from $550 to over $1400 (aside from the hospital charges). At first, this upset me to think that he does exactly the same thing each time, and in only a seven year period, the fee had more than doubled! But the more I thought about it, the more I had to agree with it. Although it is very difficult to pay these fees and would be next to impossible without insurance, I have to admire him. Those fees are his incentive for continuing to do a quality job with the least amount of physical discomfort, providing the most comfortable atmosphere possible for the patient, and maintaining a good, strong, positive attitude all along. I have had dozens of different doctors perform this procedure on me. While serving a two year mission for the LDS church in Boston, I was seen at Harvard Medical School's Brigham and Women's Hospital, where I never saw the same doctor twice. While attending BYU, I've been to University Hospital in Salt Lake City and had the same procedures performed there. But each time I see someone else, I always go back to my original doctor. Why? Because he cares! He knows my condition, my fears, my history—everything about me, and does everything in his power to make me feel comfortable. So I pay him for that.

It is important for me and for many others, I'm sure, to be able to choose the doctors they want to see and be assured the same quality health care they've been expecting and received for so long.

I truly think that if you were to take a random sample of Americans, they would agree that something has to be done. We can't continue to let these costs soar. I believe they would also tell you that the White House's plan is not the cure to what ails this problem. I certainly don't have any answers nor do I propose any solutions, but I do know this: that President Clinton's plan is not the answer. It simply won't work. It will cost billions and billions of dollars we don't have, and will place the health care of Americans in jeopardy.

Lately the news media has reported that things are slowly coming to a head on Capital Hill and the vote is likely to occur sometime in August or September. I get the impression from these reports that a majority of Congress is leaning in favor of the President's plan hoping that by simply voting on the issue, the problem will go away. Truly something of this magnitude needs to be studied much more carefully. We need more brainstorming, more proposals, and not simply jump at the first plan but before us. As I look back on President Clinton's track record, I must admit it is an impressive one. He has narrowly passed nearly every major bill he has proposed. His strategy seems always to be the same: pull the fence-sitters into his office (behind closed doors) and push push push until he gets the one vote he needs to pass.

Now I realize that nothing I have written is new to you, that you must get thousands of these letters each day, but Senator, I fear for the future. I honestly fear the passage of this bill. I urge you to please consider the needs of this great nation before any personal political agenda you may have regarding this issue. As I mentioned before, this issue is just too important for "politics as usual." I urge you to please vote against the Clinton Health Security Act, and hope that you will urge your colleagues to do the same. And if by chance, the President calls you to his oval office and does whatever he does behind those closed doors, I pray you will remember why I sent you to Washington—to represent me—not the President.

As for me, I honestly don't know what I'm going to do when next May rolls around and I lose my insurance. I have faith that something positive will happen and my needs will be met. But I do know that this plan is not the answer, and I hope you do to.

Respectfully yours,

RODNEY E. RINE.

RECESS UNTIL 2:15 P.M.

The PRESIDENT pro tempore. Under the order, the Senate will now stand in recess until the hour of 2:15 p.m. today, at which time the Senate will resume consideration of the pending matter and the Senator from North Dakota will be recognized.

Thereupon, at 12:40 p.m., the Senate recessed until 2:15 p.m.; whereupon, the Senate reassembled when called to order by the Presiding Officer (Mr. BYRD).

The PRESIDENT pro tempore. Under the order previously entered, the Senator from North Dakota [Mr. DORGAN], is recognized.

Mr. DORGAN. Mr. President, thank you very much.

THE FEDERAL RESERVE BOARD

Mr. DORGAN. Mr. President, I am told by my young son—and I believe him to be accurate because he knows more about dinosaurs than most anyone I know—that the largest living thing ever to have roamed the Earth is a dinosaur called the Brontosaurus. The Brontosaurus was apparently as large or nearly as large as an 18-wheeler truck with a brain no bigger than the size of my fist.

Using dinosaurs as a comparison, the Federal Reserve Board, which is a remaining dinosaur on our Government, today, took action to increase interest rates by one-half of 1 percent once again. I will not describe the brainpower it took to do that because we have a lot of people who have good academic credentials, and I think they are plenty smart, down at the Federal Reserve Board. But it surely is an institutional dinosaur. It is a large central agency accountable to no one in this country.

The Federal Reserve Board met this morning in secret, behind closed doors, and took action to hike interest rates by one-half of 1 percent. The Fed's best friends are the big-money central banks, and they serve that constituency faithfully, I guess.

This is the fifth time in 7 months they have increased interest rates in our country. It is an outrage. Do they live in a different world down at the Federal Reserve Board? Do they breathe different air or lack oxygen when they make decisions? What on Earth would allow them to conclude that what we need to do is increase interest rates at a time when—coming out of a recession—we have gotten toward cruising speed in our economy, but are beginning to slow down because of previous actions of the Fed? Nevertheless, they take more action to put the brakes on the American economy. It is exactly the wrong solution at the wrong time.

There is no credible evidence of inflation. For 4 successive years inflation has decreased, and it continues today. The action by the Fed is wrongheaded, and it will hurt this country.

Inasmuch as we created this institution early this century, I hope that enough of us care about what they are doing to decide to reform the Federal Reserve Board. It is now a strong central bank accountable to no one. It recognizes and pays homage to the big money center banks and to those vested interests in this country that have wealth. They take action to support and to nurture their interests at the very time the action injures the interests of most American families, and Main Street businesses.

Mr. President, I needed to say that because the Fed just in the last hour, raised interest rates which will be a tax on every American family. It is bad public policy. We cannot do much about this at this moment because it is unaccountable. But we ought to do something in the long term to reform this institution so it is more accountable to the American people.

HEALTH CARE REFORM AND THE HEALTH SECURITY ACT

Mr. DORGAN. Mr. President, let me go on to the subject for which I sought time today in the U.S. Senate. The subject of health care, hospitals, and all of the issues that surround the issue is very difficult for me to talk about because of the significant tragedies in our family that are attached to the health care system; sitting night after night and day after day in intensive care waiting rooms, and praying for miracles and the breathtaking and spectacular changes in medicine that will save someone you love, and it does not work and does not happen.

I cannot talk very much about it except to tell you that I fully understand that when someone you love is in trouble and has a health care problem, cost is not an issue. The cost of the operation, the cost of the surgeon, the cost of hospitalization, the cost of the very best technology available anywhere in the country is not an issue. It does not matter. You want someone to save the life of someone you love. That is kind of what health care is today, breathtaking, spectacular advances to do

things we never before thought possible. People whose lungs are not functioning and whose heart is gone get a double lung and heart transplant. The definition of a dead person was once somebody whose heart was not working and lungs were gone. Now we can transplant a new heart and lungs all at once. It is breathtaking.

Those are the spectacular successes we read about and know about. There are just as many spectacular failures. All along the way, enormous amounts of money are spent in various ways to try and advance medical care. Some of it is routine, the ordinary daily health care services people need. Some is on the cutting edge of new technology, trying to save lives that we before could not save.

I grew up in a town that had a doctor—one doctor. There were 350 people in my hometown. He was old Dr. S.W. Hill, a wonderful man, who came there and stayed 55 years. Our neighbor took his kid, Alton Ivy, to the doctor because his tooth ached. We did not have a dentist in my hometown. Doc Hill looked at Alton and got him to open his mouth, and he decided he had to have a tooth pulled, so Doc pulled out Alton's tooth. The problem was Doc Hill pulled the wrong tooth. Alton's dad was pretty upset, and the doctor explained that he did the best he could; he was not a dentist, and he sometimes made mistakes. With Alton, he pulled the wrong tooth.

My opinion about health care in this debate is that there is clearly a national ache of significant proportions. You cannot ignore that. But, we have to be careful not to pull the wrong tooth. I am worried that may be what we are about to do.

I would like to present some information today that I hope my colleagues will consider as we try to respond to this issue and decide what to do with respect to health care reform. There are those around here who say, well, let us essentially do nothing and let the market system take care of this. Let us be happy and do nothing. That is the easiest possible solution, to do nothing. That would not be the right approach. We must do something.

Too many people are without coverage. Too many people are sick for whom health care is not readily available. We must especially do something about costs. We are responding when the issue is skyrocketing costs in health care by talking largely about coverage. And that, I think, is the weakness of our approach. Is coverage important? Absolutely. Health care coverage is essential. I will talk more about that in a minute. But cost is what is driving this problem. As health care costs skyrocket month after month and year after year, it takes health care out of the reach of far too many American families. If we do not do something about the skyrocketing costs we are chasing, we will not succeed in expanding health care coverage because health care will always cost too much.

It is not that coverage is not a problem. It clearly is. We need, it seems to me, to make certain every American has access to health care. I believe health care ought to be a fundamental right. Some particular child today ought not to have a circumstance exist where whether that child gets to a hospital or clinic is a function of how much money that child's mother or father has.

So coverage is an issue. Yes, we ought to address coverage, and we ought to have universal health care coverage. There is no question about that. But the relentless, gripping, nagging problem of escalating, skyrocketing health care costs, if ignored, will mean we will never attain universal coverage in our country. It will mean that families and employers and the governments that finance the Medicare and Medicaid programs will simply not be able to contain the monster that is eating away at our ability to pay for health care, and that is skyrocketing costs.

In short, we are answering the wrong question first. People want something done to bring down the cost of health care. And we are telling them that with a new program, we can increase the coverage of health care now. But can we do that without controlling costs? No, I do not think so. I do not think it is possible.

The appetite for health care in this country is inexhaustible. We all know that. If you have breast cancer and have a 10- or 20-percent chance of a cure with an experimental operation, a bone marrow transplant that will cost $250,000, if it is you, do you want somebody to pay that $150,000 or $250,000? Of course, you do. There is an inexhaustible demand for health care.

If you go to the cafe in my hometown and ask people about health care, I will tell you what you will discover: A discussion and a conversation about cost. They will ask, "Why does it cost $300 to get three stitches put in your index finger?" That is what one North Dakotan asked. "Why did it cost $18,000 for 3 days in a hospital?" The hospital bill including the use of an operating room for 4 hours without the physician fee, was $18,000. Why did it cost that much? "Why did it cost," they will ask, as Judy did, "$10,300 for a 3-day stay in a hospital last month?" Or "Why did it cost," Tricia asked, "for outpatient surgery, with a hospital stay from 8 a.m. to 2 p.m. on the same day, $13,000?"

How did hospital prices increase 413 percent from 1980 to 1991? The average total charge per day for inpatient care in hospitals for a Medicare beneficiary is $1,230. Yet, a third of our hospital beds are empty, and many of those hospitals that are not full are expanding and building. A 1993 study found hospital expenditures per day to be over $1,000 in the United States; $400 in Canada; and less than $250 a day in France, Germany, Japan, and Great Britain. And physician fees are extremely high as well.

In 1989, U.S. physicians, on average, had incomes more than three times their British, French, Swedish, and Japanese counterparts. In 1990, the Canadian Province of British Columbia arranged for some Seattle hospitals to do open heart surgery for some Canadian patients. The surgeons were paid $4,500 for the heart surgery done in Seattle. A surgeon would have gotten $2,500 for exactly the same surgery in Canada. And actually, the fee for a United States consumer in Seattle for that same surgery would have been $6,000, but the Canadians were able to negotiate a better deal. I note that the ratio of physician income to an average person's overall income in the United States is 5 to 1; compared to 3.7 to 1 in Canada; 4.3 to 1 in Germany; and 2.3 to 1 in Great Britain.

I asked if I could get some information on the comparative costs of procedures, operations such as a tonsillectomy, appendectomy, or a hysterectomy, here in the United States and other nations. There is not much information but CRS was able to find this comparison of Canada to the United States. A coronary artery bypass cost $16,000 in Canada and $38,300 in the United States. A cesarean section was $3,700 in Canada and $6,700 in the United States. An appendectomy, uncomplicated, was $2,500 in Canada and $5,700 in the United States.

I have mentioned this before, and I will do it again very quickly. I have talked several times about prescription drug costs. Let me just refer to a couple of charts that I have shown Members of the Senate before. Valium is certainly a drug that is familiar to a lot of the American people. The same drug, by the company, selling the same pill, in the same bottle, costs $4 in Sweden, $4 in Great Britain, and $9 in Canada. For the same dose of the same pill, made by the same company, they charge $49 in the United States. They say to the U.S. consumer: If you need Valium from us, we have a separate way we charge. We are going to charge you 10 times more than we charge other consumers.

Here is another comparison. I have a grid sheet of wholesale price ratios for 20 of the 100 top-selling drugs in the United States. Inderal is $34 in Sweden, $43 in the United Kingdom, $122 in Canada, and $428 in the United States for exactly the same number of pills produced by the same company and sold in these different countries.

There is Xanax, a drug prescribed for anxiety. As you can see on the chart—$10, $15, $20, but for the U.S. consumer, a special deal, they overprice it.

I have many of these charts. When I offer an amendment on this subject I intend to go through them in some detail.

Finally, Premarine, an estrogen replacement, the largest selling drug in this country, as a matter of fact. In Sweden it wholesales for $93, the same bottle, the same pills produced by the same manufacturer; $100 in Great Britain; but they say to the United States consumer you get a special price from us—triple—we triple the price.

Physician fees, hospital costs, prescription drug costs—people are worried about prices. The cost of health care keeps rising. The salaries of hospital administrators—but first, the salaries of prescription drug manufacturers. They say they need these prices for research and development. The CEO of one major drug company makes as much in a year as the combined salary of every Senator serving in the U.S. Senate. He makes as much money by noon in one day as the average American worker makes working all year long.

One insurance company executive is paid $52.8 million. The CEO of one Blue Cross/Blue Shield plan, an empire that was losing money hand over fist, was making $600,000 a year. Another CEO of a Blue Cross/Blue Shield plan was making $800,000 a year. Another one made $1 million last year. Another Blue Cross/Blue Shield CEO got a $4.6 million retirement package.

Cost is the issue. In every stage of this debate, why does health care cost so much?

The fact is we do not have a system in which price is the competitive regulating mechanism that is normally associated with the market system.

I have studied Adam Smith. Most of us studied Adam Smith. The cloak of the invisible hand established price as a mechanism by which competition existed.

It does not exist in health care. There is an inexhaustible demand for health care services. The fact is we do not have typical price competition. In my home State, we have 640,000 people; and guess what: Six separate locations where you get open heart surgery. Do we need that? Of course, we do not. But the providers compete based on adding additional services, not price. One does open heart surgery, the other provider says, "We have to do that in order to compete." One gets an MRI, and the other says, "We have to get an MRI." One has a CAT scan, and the other says, "We have to have one."

Competition in health care means duplication of services, and, therefore, higher prices. You do not hear a Tom Bodett advertise like Motel 6 to keep the light on 24 hours a day for you. You do not hear, "Come over to the hospital; we have a cheaper room for you." Competition in health care is not based on price. It is a fact. Those who stand on the floor ad nauseam talking about competition, how some sort of managed competition is going to magically drive down prices or costs in health care, are simply wrong. It is not going to happen.

With all of that as background, let me turn to some information I have developed about all of the plans that exist. Let me say at the start this President deserves a lot of credit. We would not be talking about health care if it were not for this President. Health care costs are gobbling up the Federal budget, the family budget, and business budget, which we must do something about. We would not be discussing it had we not elected Bill Clinton. So I give him credit for this. Let me credit also the majority leader for bringing the plan to the floor. The easiest possible thing do is to bring nothing to the floor; let us obstruct, wait and do nothing.

Most important to me is let us do the right thing. The right thing is to do something to put the brakes on skyrocketing costs. None of the plans now discussed—none of them—effectively does that.

Let me explain the problem with this chart. This chart shows health care costs as a percentage of gross domestic product. Our gross domestic product or GDP is the sum total of everything we produce in the country, the income, in effect that we are able to use. If you add it all up and compare it to health care costs, we spend far more on health care than any other country.

In fact, President Clinton during the State of the Union Address said we spent 14 percent of our GDP on health care costs, Canada spends 11, and no other country spends 10. In Germany they had a special session of the German legislature when health care costs went up two-tenths of 1 percent of GDP. I believe it was somewhere around 7.6 or 7.8 percent. They called a special session. It was a calamity for them. We are not at 7, 8 or 9 percent. We are at 14 percent and rising, and rising quickly. We are far, far above any other country in the claim health care costs have on our total resources.

Let me show you a chart that says if there is no health care reform and we just go on like we have been going along, according to the Congressional Budget Office, health care costs will go from 14 percent of gross domestic product to over 20 percent in 10 years. In other words, we are going to increase by a third the claim on our national income for health care. That is if we do nothing.

If we pass the Clinton plan, which I think is no longer before us, but nonetheless, if we pass the Clinton plan as is, what we have is we go from 14 percent up to close to 19 percent, and the Clinton plan, incidentally, has cost containment in it that is tougher than any other plan we have considered. If we pass the Finance Committee plan, which was guided by the mainstream or moderate group, we go from 14 percent of GDP to over 20 percent of the gross domestic product. If we pass the Mitchell plan, health care increases as a percent of our gross domestic product from 14 percent to over 20 percent. The Dole plan is not yet scored by the Congressional Budget Office, but I cannot believe it would have any better numbers than any of the others because it probably will have the least amount of bite in it as far as controlling cost. Essentially, I think it mirrors where we are today in inexhaustible growth of health care costs.

This chart is a summary of all the plans. What you see from this chart is that no matter what plan we pass that currently exists, we are off debating coverage and not biting on cost control. If we do not have the opportunity to and do not have the will to say that we are going to do cost containment and put some cost controls in place that bite, we will not be able to get costs under control. We must do something in order to keep this country's health care costs at somewhere around 14 or 15 percent of gross domestic product. Otherwise, our health care reform efforts we will surely fail.

Now, the answers that come in this debate are fairly predictable. This is politics, fortunately or unfortunately. I do not happen to think politics is bad. John Kennedy said every mother's hope was that her son would grow up to be President as long as they do not get involved in politics. Politics is the process by which we make decisions.

The politics of the Senate increasingly these days is we tend to retreat into familiar terrain, into familiar campgrounds. The campground on that side of the aisle is retreating to positions of saying let us really do nothing, or let us do nothing and pretend we did something, but let us do very little and make it seem like it was a lot. That is very familiar ground for that side of the aisle.

Our side of the aisle tends to try to put our suit right away and say let us immediately help people. There is no more laudable goal than that, because we have a lot of people suffering and a lot of people who need help.

But going to a spending program immediately without addressing rising costs will not solve this problem. Some say to me when I show them these charts, you know what you are missing? We are putting 30 million people more into this health care system. Of course, it would cost more. I say they do not understand. The whole debate about health care is that the 30 million people are now getting health care, at least some semblance of health care, and there is an enormous cost shift. They are already in this system to a large extent. We ought to, it seems to me, be able to construct a system with

cost containment that bites in a real way. That is the toughest thing we have to do around here, because it is going to offend everybody. But if we do not do that, we will not ever, in my judgment, be able to provide adequate coverage because we will not have constrained costs.

When we get up to 20 percent of our GDP committed to health care, we are not going to be able to deal with that in the Federal budget. Families are not going to be able to deal with that in the family budgets.

It is my hope, as we move along here now, in the midnight hours tonight, or whenever we are going to try to wrap this up, that we will understand a couple of things.

One, this President and this majority leader have decided an important element in this health care debate is coverage. And they are absolutely right. Too many people today are sick and are not getting adequate care. No mother in this country should worry that when her children get sick she may not be able to get them to a doctor because she does not have enough money in her wallet. Coverage is important.

But we will not advance the interests of coverage unless we do something in health care reform that bites on cost containment. We cannot have a health care system that eats up from where we are today an additional one-third of its claim on our gross domestic product and finish this job and say we did a good job. If we pass a bill that deals only with coverage and go home, we will have left the most significant challenge in front of us.

As I was coming over today I pulled something out of my files, because when my mother passed away she had left, in a series of files for us children, things that she had kept and collected. I suppose everyone has something like this. My mother had kept a hospital bill from St. Joseph's Hospital in Dickinson, ND. When I was a little tyke just able to walk, I had a burst appendix and nearly died. They said another hour or so I would not have made it. I got to the hospital and had emergency surgery—fairly significant surgery in those days. I was hospitalized for 6 days. I had extensive care. And my mother kept the bill for that extensive hospitalization. It was $71.81.

It was 6 days in the hospital, 6 days of room charges at St. Joseph's Hospital in Dickinson was $39. But then you add to that—that is not all they charged—they wanted to charge for the operating room as well, and this was surgery, I understand, that took many hours because it was very difficult surgery at that time. And they charged $10 for the use of the operating room and $10 for anesthesia and $3 for an x-ray.

When people talk of the good old days, I suppose there were some aspects of the good old days we would like to go back to. And $70 hospital bills might be one. But we cannot reclaim the good old days, nor would we want to with respect to some of the miracles and advances and breakthroughs and the breathtaking changes that have occurred in health care.

Breathtaking changes and miracle cures are important to all of the American people only to the extent that they have access to them. That is why I think my colleagues—my colleague from Minnesota is on his feet about to speak. No one is more aggressive than he is to talk about coverage. He is absolutely right, coverage is essential. But I am just telling him, he and others, that if we do not effectively deal with costs, with cost controls and cost containment that really bites, then we will not succeed.

I might say to folks on the other side of the aisle who come here and talk about competition and so on, the last thing, in my judgment, they would ever embrace would be anything that restrains in any way anyone's ability to charge any amount to any American. I just cannot believe that. Because this is not a market system that works in the traditional market ways.

So I guess I would close pretty much as I began. I full well understand the necessity of health care from a personal standpoint and I hope that no one will believe in the next few days the solution is for us to do nothing. That is not a solution. The solution is for us to do something and to do the right thing. The right thing in my judgment is two steps: Decide together that the market system does not work to control health care costs; and to find an effective way—fair to everyone, fair to providers and fair to consumers—to put us on a course of restraining, in an adequate way, health care costs.

And second and importantly, make sure we finish when we are on a track and give every American family the assurance that they will have health care coverage, coverage they can afford and coverage that represents quality health care.

I hope if and when we can put the brakes on skyrocketing health care costs, the American families will once again give this institution the credibility that I think this institution can have by tackling tough problems in a timely way.

I yield the floor.

Mr. WELLSTONE addressed the Chair.

The PRESIDENT pro tempore. The Senator from Minnesota [Mr. WELLSTONE].

Mr. WELLSTONE. Mr. President, first of all, let me thank my colleague from North Dakota. One of the things I most appreciate about Senator DORGAN, since I come from Minnesota, a neighbor of North Dakota, is all of the ways in which Senator DORGAN is so rooted in the people that he represents.

The kind of sensitivity toward and feel for regular people he demonstrates is rare. I do not think there is anybody in the U.S. Senate, whether we are talking about the Federal Reserve System and interest rates or the ways in which those kinds of decisions can make or break people's lives, or health care, who does a better job of really representing a lot of people who quite often do not have a voice here. I thank the Senator.

The other thing I would say, and I promised my colleague from Iowa that I would be relatively brief so I do not want to get started on this, but I wanted to say to my colleague from North Dakota that I believe he is absolutely on target. He said I was a fierce advocate for universal coverage—yes. But I think unless we have cost containment—I mean, if 37 percent of our gross domestic product by the year 2030 is spent on health care, it is going to bankrupt us. I think we have to be very serious about cost containment.

The question is how to contain health care costs. I just simply do not buy the argument that the way we contain the costs is by essentially undercutting services for people, or not covering people, or denying people care that they and their loved ones really need.

I have to say to the Senator from North Dakota, one of the things that attracted me to the single payer option from the very beginning—since everybody keeps talk about the Congressional Budget Office—is that there is simply not another proposal that has been presented that does nearly as well by way of CBO scoring. CBO's latest scoring of the single payer bill pointed out that single payer, 1997 to 2003, has the potential to save up to $700 billion as compared to the status quo, projected over that 6-year period. That is not an insignificant amount of money, especially when you are talking about a health care bill that would make sure that everyone was covered with a comprehensive package of benefits, including catastrophic care. So I think he is right on target and I hope we get serious about universal coverage. All of which is a bridge to what I would like to really focus on, Mr. President, for maybe a few minutes.

Mr. President, let me start out by saying that I recognize that I tread on sensitive ground, and I want to make sure my colleagues understand the analysis I am trying to make, and that they know it is not an analysis that attempts to criticize any particular Member of the U.S. Senate or the House.

First of all, I ask unanimous consent that a Washington Post piece dated Monday, August 15 titled "Health and Insurance Contributions to Senators" be printed in the RECORD.

And second, I ask unanimous consent that a New York Times piece titled

"Lawmakers Feel the Heat From Health Care Lobby," which is dated Tuesday, August 16, today, be printed in the RECORD.

The PRESIDENT pro tempore. Without objection, it is so ordered.

(See exhibit 1.)

Mr. WELLSTONE. Mr. President, I am pleased that these two major newspapers have really analyzed this mixture of money and politics in the health care debate. I have to say that much of the struggle over whether or not we will have a fundamental health care reform has to do with our failure to yet enact fundamental campaign finance reform legislation. I want to talk about that campaign finance reform bill in a moment.

Citizen Action came out with a study recently—an analysis of Federal Election Commission data. From January 1993 to May of this year, the health care industry made $26.4 million in political contributions to Representatives and Senators. In March, it was a staggering $4 million, just in that 1 month alone.

Other data, Mr. President: During Presidential and congressional elections, the 1990–92 cycle, the health industry, broadly defined, spent almost $42 million. Common Cause just came out with a study of these contributions, which I mentioned the other day on the Senate floor, Mr. President. This is a study of PAC contributions—just PAC contributions—to the U.S. Senate over a 6-year period, January 1987 to December 1993. During that time, business PAC's contributed $72 million; labor PAC's, $16 million. That is about a 4-to-1 ratio.

I want to just make three more points. First, I think that we have to figure out a way of financing our campaigns so that people can have more faith in our process. By the way, again, I am not talking about the wrongdoing of individual officeholders, I am talking about something different. I just think that when this kind of money is contributed at the same time that we are dealing with an issue that is so important to people's lives, it is difficult for people to have confidence that we are representing the public interest, that we are representing them.

I think part of the reason there is such anger in the country is many people feel ripped off and they think this process is just driven by a big money game. It is not just that. But I do not think it looks right, and I do not think it is right. I said before on the floor of the Senate, and I say it one more time: it is comparable to the referee of a soccer game or football game receiving contributions from the two teams before the game starts. People would say, "We're not sure that referee can make rigorous, objective decisions that would be best for everyone." That is my first point.

My second point, Mr. President, is that I think it does have a bearing on policy. From the New York Times front page today just a few figures: From January 19, 1993, through May 31, 1994, the American Medical Association gave $977,000; the American Dental PAC gave $630,000; the National Association of Life Underwriters, $612,000; American Hospital Association, $551,000; American Nurses Association, $444,000; Independent Insurance Agents of America, $371,000; American Family PAC, $345,000.

We have before us some important decisions we have to make on policy. I would like to talk about the ways in which I fear that this virtual wall of money sometimes stands between the people we represent and Senators and Representatives. For example, how do we contain costs? My colleague from North Dakota just spoke eloquently about the need to contain costs.

Mr. President, do you know what the CBO has said rather clearly? If we want to have cost containment, if we want to make sure that health care costs do not continue to skyrocket, the CBO always focuses in on the importance of insurance company premium caps. That is now off the table. For some reason that is off the table. Does it have anything to do with the power of the insurance industry? Does it have anything to do with their ability to effect the tenure or lack of tenure of Senators and Representatives? I hope not, but I think this is a way in which people have every right to be skeptical as to whether or not the insurance industry perhaps is better represented than the vast majority of people.

Second example. Employer mandates. Every time I am in a debate with my colleagues on the other side of the aisle, they talk about how people now are beginning to question whether any health care reform bill should be passed. That is true; $100 million will be spent on TV and other advertising before this is all over and plenty of people are frightened and scared, and people have a right to raise questions. I would not deny any citizen in this country that right.

But the polls also show overwhelmingly that the vast majority of people, throughout all this attack, still say that they believe each and every person should be covered, because they know that if some people go without coverage, it could be them if they become sick or lose their job, and people are absolutely convinced that employers should contribute their fair share.

But when we talk about anything close to what we in Congress have, with our employer contributing 72 percent, or when we talk about employers contributing 80 percent, making sure that small businesses have a subsidy so they can afford that, that now seems to be off the table. Could that have anything to do with the fact that over the last 6 years $72 million in political contributions has come from business PAC's?

Finally, my last point—and this one bothers me to no end. I was in a debate today, a radio discussion, and I asked the host, a conservative, good person with an interest in federalism—you have to have a twinkle in your eye, you have to enjoy debates and discussions with people. I asked him: "Would you not agree with the proposition that if a State wanted to go forward with a single-payer plan, it would be wrong for Senators and Representatives to try and knock out of the Mitchell bill the option for States to go forward just because the large employers want to be carved out, just because the insurance industry does not want it to happen? Should it not be the case that if the people of Minnesota or Oregon or New York or Iowa themselves vote people into office who represent them and the decisions are made at the State level that they want to go with a single-payer option, should we not let States have that opportunity?"

I thought the States were to be the laboratories of reform. I thought we were a grassroots political culture. I thought we were in favor of decentralizing public policy. And, frankly, I just think there is a lot of fear about this because I think the evidence is irrefutable; that, as a matter of fact, if some States go forward, they will be able to cover everyone, it will be good coverage, comprehensive coverage, more comprehensive than in any plan that is before us right now and they will be able to contain costs. But there is this fierce opposition lining up to enable States to have the flexibility to do this.

Mr. President, could that have anything to do with the huge amounts of money that have been poured into the U.S. Congress from health care special interests? And not just by health care PAC's. There is too much emphasis on political action committees; I also mean individuals within the industry, broadly defined, who make the huge contributions.

I heard one of my colleagues the other day say, "You know, the problem is we have to contain costs and we just don't know when to say no. You have all these special interests that are asking for coverage, and we don't know how to say no to those special interests."

What special interests? People who are uninsured? What special interests? Children? What special interests? My colleague from Iowa is here. People with disabilities who are saying we hope that you will pass a reform bill that will enable us to live at home in as near normal circumstances as possible with dignified home-based care, what special interests are we talking about?

I do not see anything in the Washington Post piece yesterday or in the New York Times piece today or in any of the analyses I have made about the

mix and money in politics that tells me any of these people are the special interests. But I see a lot of evidence that there are a lot of people in this industry, a lot of large companies, a lot of hospital supply and equipment companies, a lot of the professionals, the insurance companies and all the rest that have poured an unprecedented—unprecedented—amount of money into the Congress at exactly the time we are debating this piece of legislation. I do not hear my colleagues on any of these talk shows talking about those special interests at all.

My final point, Mr. President—and, by the way, I think it would be a profound shame if those interests were able to hijack this reform effort and if we did not come through with a bill that led to the positive improvement in the lives of people.

I think this health care issue, this debate, and what is happening on the floor of the U.S. Senate speaks in as strong and powerful and direct way than anything for the need to have tough, comprehensive campaign finance reform.

I will say it just one more time. I am not talking about the individual wrongdoing of any office holder. We are all trapped in this system. People run for office and you have to raise—what is it?—over a 6-year period the standard now is $13,000 a week. You have to raise this money to be a viable candidate, so we are told. The campaigns are hugely expensive.

So people try to raise the money, and they raise the money from the people who have the money to give. But it undercuts representative democracy. If the standard is each person counts as one and no more than one—and it should be— we have moved dangerously far away from that.

So I hope that Senators and Representatives will get going on this conference committee. We passed a campaign finance reform bill. It is deadlocked. That deadlock should be broken.

Now, Members of the House say to Senators, you all want us to abolish PAC's. How convenient it is for you to say that, Senators, because about 60 percent of the big money you raise is through individual contributions, large contributions. We raise it from labor and women's groups and environmental groups and other groups as well, but we would like to focus on how you raise the money.

It seems to me there can be a compromise. At the very minimum, the bill we passed called for an agreement upon spending limits. That is a huge first step. Talk about getting rid of soft money, talk about having some debates, having some vouchers for being able to buy advertising, talk about ways in which we can begin to get some of this big money out of politics.

Now, if the House of Representatives, Mr. President, is willing to phase out PAC contributions, then it strikes me that Senators should be willing to begin to limit further some of our large contributions. As I understand it, one of the proposals is that no more than a third of the money Senators raise should be in small contributions. I would not settle on a particular figure. I would want it to be something that worked. But it does seem to me, Mr. President, that we could drop some of our contributions or percentage of what we raise overall in exchange for the House being willing to phase down PAC contributions. This conference committee could finally meet and bring back to the floor of the Senate, and the House a campaign finance reform bill.

I cannot think of a better reason to do it than what is happening in this health care debate right now. All this money pouring in, the same imperative of running for office, the same money chase, which undercuts representative democracy and undermines people's faith in this process.

I have come to know colleagues after 4 years here, and there are a lot of people on both sides of the aisle who are very committed to public service, very committed to doing the right thing, some of whom at this moment do not agree with me on this particular issue. That is beside the point.

The point is we ought to really demand that this conference committee get moving. We ought to demand that there be some kind of campaign finance reform bill passed this year. We ought to demand that we get some of this big money out of politics. We ought to demand that we move toward a system of representative democracy.

Mr. President, at this point I yield the floor.

EXHIBIT 1

HEALTH AND INSURANCE CONTRIBUTIONS TO SENATORS

An analysis released last week by the advocacy group Citizen Action shows that health and insurance companies have contributed $40.1 million to members of the U.S. Senate over the last 15 years. The analysis summarizes campaign contributions received from health and insurance political action committees (PACS) and from individuals giving more than $200 during the same period. The figures are derived from Federal Election Commission reports and include donations from PACs such as those affiliated with health care professionals, hospitals, pharmaceutical firms, clinical laboratories and insurance companies. The individual donors counted identified themselves on FEC reports as being affiliated with either the health or insurance industry. Citizen Action supports a single-payer Canadian style plan for health care reform:

Phil Gramm (R–Tex.)	$1,235,520
Bob Packwood (R–Ore.)	1,027,218
Dave Durenberger (R–Minn.)	1,021,054
Bill Bradley (D–N.J.)	978,761
Orrin G. Hatch (R–Utah)	958,299
Dan Oates (R–Ind.)	913,273
Arlen Specter (R–Pa.)	895,786
Christopher S. Bond (R–Mo.)	733,011
Connie Mack (R–Fla.)	732,383
Richard C. Shelby (D–Ala.)	724,496
John H. Chafee (R–R.I.)	721,098
Frank R. Lautenberg (D–N.J.)	717,192
Robert J. Dole (R–Kan.)	707,794
Alfonse M. D'Amato (R–N.Y.)	693,903
Daniel Patrick Moynihan (D–N.Y.)	670,578
Bob Graham (D–Fla.)	639,243
John D. 'Jay' IV Rockefeller (D–W.Va.)	638,645
Charles E. Grassley (R–Iowa)	638,169
Thomas A. Daschle (D–S.D.)	620,822
Christopher J. Dodd (D–Conn.)	612,154
Kay Bailey Hutchison (R–Tex)	611,009
Tom Harkin (D–Iowa)	607,423
Richard G. Lugar (R–Ind.)	602,772
Jim Sasser (D–Tenn.)	568,671
Dianne Feinstein (D–Calif.)	534,356
Don Nickles (R–Okla.)	530,658
Trent Lott (R–Miss.)	524,303
Max Baucus (D–Mont.)	523,364
John C. Danforth (R–Mo.)	522,599
Strom Thurmond (R–S.C.)	514,512
Mitch McConnell (R–Ky.)	513,436
Joseph I. Lieberman (D–Conn.)	494,730
George J. Mitchell (D–Maine)	491,633
Richard H. Bryan (D–Nev.)	478,227
William V. Roth Jr. (R–Del.)	467,402
Donald W. Riegle Jr. (D–Mich.)	458,167
John Breaux (D–La.)	450,707
Ernest F. Hollings (D–S.C.)	443,763
Kent Conrad (D–N.D.)	440,853
Slade Gorton (R–Wash.)	428,956
John McCain (R–Ariz.)	421,253
Bob Kerrey (D–Neb.)	417,999
Jesse Helms (R–N.C.)	416,530
Howel T. Heflin (D–Ala.)	413,313
Paul Simon (D–Ill.)	403,270
Harry M. Reid (D–Nev.)	398,722
Dennis DeConcini (D–Ariz.)	396,683
Hank Brown (R–Colo.)	369,243
Jeff Bingaman (D–N.M.)	347,695
Byron L. Dorgan (D–N.D.)	343,846
Harris Wofford (D–Pa.)	342,921
Carl M. Levin (D–Mich.)	342,170
Larry Pressler (R–S.D.)	338,687
Wendell H. Ford (D–Ky.)	332,440
J. James Exon (D–Neb.)	326,825
Charles S. Robb (D–Va.)	325,677
Barbara A. Mikulski (D–Md.)	313,912
Edward M. Kennedy (D–Mass)	308,689
John Glenn (D–Ohio)	293,312
Thad Cochran (R–Miss.)	292,217
David Pryor (D–Ark.)	290,914
Alan K. Simpson (R–Wyo.)	287,123
Pete V. Domenici (R–N.M.)	286,579
John F. Kerry (D–Mass.)	282,109
Malcolm Wallop (R–Wyo.)	262,754
James M. Jeffords (R–Vt.)	250,791
Dale Bumpers (D–Ark.)	250,185
J. Bennett Johnston (D–La.)	247,066
Barbara Boxer (D–Calif.)	244,282
Judd Gregg (R–N.H.)	238,749
Daniel K. Inouye (D–Hawaii)	236,300
Mark O. Hatfield (R–Ore.)	231,665
John W. Warner (R–Va.)	223,690
Robert C. Smith (R–N.H.)	205,700
Larry E. Craig (R–Idaho)	198,676
Paul Coverdell (R–Ga.)	197,807
Frank H. Murkowski (R–Alaska)	194,950
William S. Cohen (R–Maine)	193,091
Ted Stevens (R–Alaska)	188,750
Sam Nunn (D–Ga.)	183,037
Paul S. Sarbanes (D–Md.)	177,100
Robert C. Byrd (D–W. Va.)	170,167
Lauch Faircloth (R–N.C.)	165,960
Conrad Burns (R–Mont.)	165,700
David L. Boren (D–Okla.)	162,260
Joseph R. Biden Jr. (D–Del.)	158,393
Claiborne Pell (D–R.I.)	156,430
Howard M. Metzenbaum (D–Ohio)	145,587
Daniel K. Akaka (D–Hawaii)	129,488
Ben Nighthorse Campbell (D–Colo.)	126,919

Patrick J. Leahy (D–Vt.)	104,000
Carol Moseley-Braun (D–Ill.)	97,442
Dirk Kempthorne (R–Idaho)	92,352
Russell Feingold (D–Wis.)	87,033
Robert F. Bennett (R–Utah)	84,700
Nancy Landon Kassebaum (R–Kan.)	83,448
Patty Murray (D–Wash.)	33,052
Paul D. Wellstone (D–Minn.)	24,875
Herb Kohl (D–Wis.)	23,960
Harlan Mathews (D–Tenn.)	3,000

NOTE.—Period covered for PACS is through the most recent filing, usually June 30, 1994. Includes large donor contributions through March 31, 1994.

LAWMAKERS FEEL THE HEAT FROM HEALTH CARE LOBBY

(By Katharine Q. Seelye)

WASHINGTON, August 15.—The telephone callers to Senator John B. Breaux, a Louisiana Democrat and an influential voice in the debate over health care, are stacked up like planes over National Airport. "Senator Breaux's office. Can you hold?"

The Senator's phones are ablaze from dawn until well past dark, with the answering machine collecting at least 200 more messages overnight. Clogged phone lines are one price that he and some of his fellow legislators pay for staking out an independent position on what many say is the most heavily lobbied issue in the nation's history.

Sentor Breaux and three members of Congress talked recently about their experiences with the health care lobby, painting a picture of special interests overwhelming the decision-making process.

At least 650 groups spent more than $100 million from January 1993 to last March to influence the outcome of health care legislation, according to a recent study by the Center for Public Integrity, a nonprofit Washington group that examines public issues. The spending has only intensified since then.

"There is no issue of public policy in which the sheer strength of those special interests have so overwhelmed the process as in the health care reform debate," the center said.

Most of the money goes to the brigade of lobbyists who buttonhole members of Congress on behalf of their clients; some of the money goes directly into the campaign coffers of senators and representatives whose votes they hope to influence. Most of the clients, including many hospital and doctors' associations, oppose comprehensive changes in the nation's health care system, but others, like the leaders of some labor unions and the American Association of Retired Persons, are pushing for the Democratic leadership's bills.

"This is the biggest-scale lobbying effort that's ever been mounted on any single piece of legislation, both in terms of dollars spent and people engaged," said Ellen Miller, executive director of the Center for Responsive Politics, another Washington-based nonprofit research group. "It is more fully engaged across the country and at a higher profile inside the Beltway than ever before."

The Annenbery School for Communication at the University of Pennsylvania predicts that by October the amount spent by lobbyists on television advertising alone will exceed $60 million—more than the $50 million spent on advertising in the 1992 Presidential campaign.

Citizen Action, a consumer group, has examined the campaign contributions made by lobbyists for health and insurance interests over the years. It reports that for the last 14 years, the political action committees representing those interests contributed more than $150 million to Congressional re-election campaigns to "keep health reform off the national agenda."

Citizen Action says these political action committees are spending more than $2 million a month to modify a health care overhaul or kill it outright. They contributed $26.4 million to campaigns from January 1993 to last May, with the biggest donations going to members of committees that produced health care legislation.

For example, Citizen Action said, members of the House Ways and Means Committee and the Energy and Commerce Committee received, on average, $27,000 more in this session of Congress than in the previous session, while their colleagues who served on no health-related committees received an average increase of $3,000 over the same period.

In the Senate, the report said, members of the Finance Committee, which produced a proposal that George J. Mitchell of Maine, the majority leader, drew on for his bill, received the biggest contributions, averaging $600,000 since 1979. Four members of Congress received more than $1 million from the health and insurance industry since that time. They were Senators Phil Gramm of Texas, Bob Packwood of Oregon and Dave Durenberger of Minnesota, all Republicans, and Representative Richard A. Gephardt of Missouri, the House majority leader.

Given the amount of money and the intense competition, "the Oval Office is reduced to just another trade association," said Charles Lewis, executive director of the Center for Public Integrity.

Senator Breaux said the lobbying "makes it more difficult to find middle ground." He added that pressure from unions, political parties, hospital associations, doctors and the Chamber of Commerce had already pushed some members of Congress to make commitments.

One of the most effective groups has been the National Federation of Independent Business, which represents 607,000 small-business owners. "The N.F.I.B has more people on the floor of the House than the White House has," Mr. Lewis said. "They are spending millions because billions are at stake."

Terry Hill, a spokesman for the federation, says the livelihoods of his members are at stake. "This is one of the biggest issues we have ever worked on, and it's the most irate and incensed I've ever seen the membership," he said.

In the bill introduced by Senator Mitchell, the federation has helped to stave off any requirement that employers pay their workers' insurance, at least for a few years. On the House side, the small-business lobby has helped rouse opposition to the requirement the employers pay 80 percent of the cost of their workers' insurance, as proposed in the bill offered by Mr. Gephardt.

Big business, which at first applauded President Clinton's efforts to change the health system, now generally sees less urgency in change and is pretty much against it.

"With the economy stronger and a temporary slowdown in inflation for health care, many companies believe they don't need a systemwide solution, that they can solve their own problems," Mr. Wiener said.

He added: This has clearly been startling for the Clinton Administration, which larded up its health care proposal with a lot that was very favorable to big business. But the distrust of government triumphed."

This distrust has undermined efforts by unions and other groups that have been lobbying on behalf of health care changes. While union leaders have been pushing for universal coverage and cost controls, Mr. Wiener said, many of their rank-and-file members fear they will suffer if the Government fiddles with the good coverage they enjoy now.

The lobbying has become so fierce, fractious and well-financed, said Mr. Lewis of the Center for Public Integrity, that it can "overwhelm the decision-making process."

JOHN B. BREAUX

A Must-See for Everybody

John B. Breaux says he has been hit on by "everyone from A to Z." This means not just the big, professional interests, but also musical therapists, witch doctors and wart removers, all of whom want their specialties covered.

His office, with its row of colorful football helmets and his case of tennis trophies, is now a must stop on the lobbying circuit. This is partly because Senator Breaux has yet to commit himself to a specific health care plan. It is also because he is one of the mainstream group producing its own set of amendments to the Mitchell bill. Some on Capitol Hill think this bipartisan group may provide the needed heft to get a health care bill through the Senate this session.

"Liberals want to do everything all at once and hope they got it right, and conservatives want to do nothing and take a long time to do it," he said. "I'm trying to take one step at a time and make sure we get it right. When you're in the middle, you get beat up by both sides."

Mr. Breaux, who was elected to the Senate in 1986, is not unfamiliar with the ways of Washington. He came to the House in 1972 as its youngest member—he was then 28—to replace Edwin W. Edwards, on whose staff he had served. (He came from the same small Cajun town as Mr. Edwards, who is now Louisiana's Governor.

At the start of the debate over health care, the Senator said, many of the lobbyists were useful because they provided details on subjects that lawmakers did not have time to delve into on their own. But now things are more intense.

"We've long passed informational lobbying; now we're at break-your-arm lobbying," he said.

Many are callers from orchestrated campaigns who tell him to vote yes or no. "I try to hang up on the ones not from Louisiana," he said. "People will really badger you. People will call up and be really ugly sometimes, and threatening."

"People have been scared," Mr. Breaux continued. "That's a great tactic if you want to get people to be against something. You instill the fear that Congress is going to do something to you rather than for you."

Moreover, President Clinton's initial proposal "was technically do-able, but politically not do-able," the Senator said. "It was too much, too soon, too complicated, too bureaucratic, too Washington-oriented."

Reforming health care may be extremely complex, but Senator Breaux has set what may be an even higher goal for himself. "I'm trying to achieve survival," he laughed. "I'll do well if I survive."

BILL BREWSTER

Lone Pharmacist Far From Lonely

Bill Brewster is the only registered pharmacist in the House. This makes him particularly sensitive to the pitches from the multifaceted pharmaceutical lobby that has been patrolling Capitol Hill.

But Mr. Brewster, a 52-year-old Democrat who represents a sprawling rural district in southern Oklahoma, is also a small-business

owner, a cattleman and a hunter. He is a man of many interests, and many interests have been seeking him out.

"We've heard from more groups than I knew there were in America," he said of the health lobbyists, many of whom represent hospitals, doctors and pharmacists.

"There's a lot of different pharmacy groups," he said, "and they're all at each other's throats."

The main issue within the pharmaceutical industry, Mr. Brewster said, is drug pricing. "The pharmaceutical manufacturers are on one side, and they've got every lobbyist hired in town," he said. "The ones they haven't hired are working for the National Association of Retail Druggists and pharmaceutical associations."

As a member of Ways and Means, Mr. Brewster said, he was lobbied most heavily from February until late June when the committee passed its proposed bill. "Obviously they worked the members on the committees prior to the committee votes," he said of the lobbyists. Partly because the Gephardt bill has stalled, he said, "I'm having fewer contacts right now."

Mr. Brewster was identified by Citizen Action, the watchdog group, as the ninth top recipient in the House of money from all health and insurance industry political action committees from January 1993 to May 1994. And the Center for Public Integrity identified him as among those who took the most trips sponsored by the health-care industry. Mr. Brewster took 10; the top member took 11.

"Who contributes to me has nothing to do with it," Mr. Brewster said. "I figure, anyone who contributes feels like I'm doing a decent job and wants to have good government. I try to look at an issue first off, how it affects my district."

The economy in his district is based on small businesses, farms and oil and gas interests. He said he was getting "a tremendous amount of pressure" from small-business owners, who oppose any provision to require employers to pay for workers' health insurance. He said he had received numerous letters saying, "I don't have insurance but I do have a job—please don't mandate insurance coverage that puts my boss out of business and puts me out of a job."

He is unhappy with both the Gephardt bill and a rival plan proposed by Representative Jim Cooper of Tennessee, which has attracted some Republican support, on the grounds that they try to do too much. "If we try to provide a plan that's not intrusive to the 85 percent who have insurance, provide access to preventive care for the 15 percent who don't and went home, the public would be very happy."

PAUL MCHALE

Former Marine Faces New Battles

Paul McHale of Bethlehem, Pa., has approached the health care debate with the order and determination of the most serious student in the class. A 44-year-old former marine who left the Pennsylvania Legislature to return to active duty for the war in the Persian Gulf, his mission is to conquer every detail and do the right thing.

"To do justice in evaluating any of the pending comprehensive health care plans," said Mr. McHale, a first-term Democrat, "it is absolutely essential for a member of Congress to have done an extensive amount of mind-numbing reading prior to the examination of any individual bill.

"Once you know the basic building blocks, once you know the concepts, you can quickly recognize how they're being fitted together. Now when I'm lobbied—by ordinary constituents, businessmen and women and professional lobbyists—when they come in, the dialogue becomes whether or not my position comes close to theirs and whether either of our positions can be found in one of the pending bills."

For the moment, Mr. McHale's cannot. An original backer of the alternative discussed by Representative Jim Cooper, the Tennessee Democrat, Mr. McHale said he was disappointed in the plan's final, conservative shape.

He is also unhappy with the Gephardt plan. He opposes making small-business owners pay for their workers' insurance, and he does not like expanding Medicare, which he says would not control costs.

All of which makes him a legislator in search of a bill to support. "The best way to affect my vote is to provide me with information," he said. While all the usual suspects have inundated Mr. McHale with information—last week alone, he was visited by at least two dozen lobbyists, including representatives of three drug companies, six of the largest businesses in his district, two unions, including the steelworkers, local health care plans, and four hospital associations—he is still in search of more.

This has left him open to attacks from all sides. "Yesterday a very good friend who is a well-respected leader of organized labor said I was too conservative," he said. "And right after that, the National Federation of Independent Business conducted a press conference back in my district where they criticized my position as too liberal."

"In the final analysis, I'm going to pull back in, find a quiet corner, think about what's good for our country and vote on the issue as if it were a secret ballot," he said.

With that, it is time for a House vote. Mr. McHale checks his watch and steps briskly out the door. "It takes me six minutes and 35 seconds to get there," he said. "I've got this route timed out."

JOSÉ E. SERRANO

A Caucus Leader Feels the Pressure

José E. Serrano represents the South Bronx, one of the poorest districts in the nation, its striking poverty and vast expanses of rubble made famous by visits by Presidents Jimmy Carter and Ronald Reagan. A full 60 percent of the district is Hispanic, which helped catapult this 50-year-old, two-term Democrat to the chairmanship of the 19-member Hispanic caucus in Congress.

Thus Mr. Serrano has not only the interests of his district to worry about but also the interests of his caucus. He said they are generally one and the same. But he also has to worry about the interests of New York City, and that can be cause for Angst.

The health care industry in New York provides 300,000 jobs, the city's biggest segment of service-oriented jobs, and it has been one of the fastest-growing sectors of the economy. Mr. Serrano has to worry about those jobs—many hospital workers are Hispanic—as well as ensure that the hospitals will continue to treat poor patients, regardless of their immigration status.

Another big concern is how New York's teaching hospitals, among the nation's most eminent, will fare under any new health care legislation. The bill offered by Representative Richard A. Gephardt of Missouri, the majority leader, proposes a limit on the number of medical residents at such hospitals; Mr. Serrano wants to make sure that whatever the number, Hispanics are fairly represented.

Mr. Serrano said the caucus was worried about preventive care and about whether a national health insurance system would require people to carry identification cards and what uses those cards might be put to. But it has supported the most controversial provision of the Gephardt legislation, the requirement that employers pay 80 percent of the cost of their workers' health insurance.

Mr. Serrano hears most often not from insurance companies or other giants of the health care debate, but from fellow caucus members and strictly local interests, particularly the teaching hospitals.

Mr. Serrano is sympathetic to some of the hospitals' concerns, but he wants them to admit more local residents into their training programs. "Maybe it's time for me to do a little lobbying," he said, clearing his throat, pinching his collar and straightening his tie.

In his office, which features portraits of Robert F. Kennedy and Martin Luther King Jr., Mr. Serrano pointed out that "not all the lobbying is done right here. Anywhere you are, you get lobbied."

He added, "It's people saying, 'Listen, you want this? You want that? You want this? You want that? Fine.'"

He reached for a piece of paper. "This is the White House lobbying," he said. "It has my name on it. They ran off a beautiful computer thing that singles out your district. It gives me information I didn't have, that there are people in my district who are not covered by Medicaid and Medicare and who need universal coverage."

The analysis said that 94,000 people, including 36,000 children, in Mr. Serrano's district had no health coverage. It also said that with universal coverage, the 72,000 middle-class families in his district earning $20,000 to $75,000 annually would save an average of $612 a year on insurance premiums.

The grass-roots groups, he said, "remind you of what it is they do and their value to society and why we have to be careful not to hurt them."

He said insurance companies are the "toughest" lobbyists "because they're very negative in their approach. They say, 'Everything is O.K. Why don't we leave things the way they are?' It's hard to negotiate with someone who believes no change is needed."

The leading health and insurance political action committee contributors, Jan. 1, 1993, through May 31, 1994.

American Medical Association	$977,704
American Dental PAC	630,553
National Association of Life Underwriters	612,301
American Hospital Association	551,266
American Nurses' Association	444,446
Independent Insurance Agents of America	371,260
American Family PAC	345,850

Source.—Citizen Action, a consumer group that supports a Canadian-style health system.

KEEPING TRACK—WHO GETS THE MOST

Recipients of campaign contributions from the health and insurance industries political action committees from Jan. 1, 1993, through May 31, 1994.

Top 10 Senate Recipients

1. Kay Bailey Hutchison (R-Texas)	$611,009
2. Joseph I. Lieberman (D-Conn.)	294,020
3. Connie Mack (R-Fla.)	293,455
4. Daniel Patrick Moynihan (D-N.Y.)	280,485
5. John H. Chafee (R-R.I.)	272,549
6. Orrin G. Hatch (R-Utah)	267,141
7. Dianne Feinstein (D-Calif.)	235,755
8. Bob Kerrey (D-Neb.)	223,299
9. Edward M. Kennedy (D-Mass.)	221,439

10. Kent Conrad (D-N.D.)	216,200
John B. Breaux (D-La.)	5,250
Top 10 House Recipients	
1. Jim Cooper (D-Tenn.)	$540,145
2. Richard A. Gephardt (D-Mo.)	228,476
3. Jon Kyl (R-Ariz.)	201,758
4. Pete Stark (D-Calif.)	190,245
5. Jack Fields (R-Texas)	190,215
6. Michael A. Andrews (D-Texas)	176,925
7. Dan Rostenkowski (D-Ill.)	169,050
8. Newt Gingrich (R-Ga.)	141,611
9. Bill Brewster (D-Okla.)	130,614
10. Robert T. Matsui (D-Calif.)	129,354
Paul McHale (D-Penn.)	8,540
Jose E. Serrano (D-N.Y.)	7,000

Source.—Citizen Action, a consumer group that supports a Canadian-style health system.

Several Senators addressed the Chair.

The PRESIDING OFFICER (Mr. MATHEWS). The Senator from Iowa.

Mr. HARKIN. Mr. President, I thank the Chair. I will not take too much time, I say to the Senators seeking recognition.

Mr. President, I wish to compliment and thank again my friend and colleague from Minnesota for his very eloquent words. He is right on the mark on the issue of trying to get back to representative democracy, and we will not do it until we have adequate campaign finance reform. So I thank the Senator for his contribution in that area.

ACTION BY THE FEDERAL RESERVE

Mr. HARKIN. Mr. President, I wish to depart for just, hopefully, no more than 5 minutes from the debate that has been ongoing about health care to talk about something that happened just about 2 hours ago that in all of the discussion and debate we are having about health care I think may have a more drastic impact than some of the things we are doing right now, with more immediate impact on Americans and their lives.

Less than 2 hours ago, the Federal Reserve Board announced that there would be another hike in interest rates. There will be an increase in the Federal funds rate and the Federal discount rate by a full half point. I believe that is going to be very damaging to our Nation's economy. While that increase may be beneficial to those with substantial direct interest in the bond market, it is going to be harmful to average, ordinary Americans.

There are three things on which I think the Federal Reserve Board is wrong. First, inflation is not a threat at this time.

Second, the economy is not overheating.

Third, increasing interest rates will without a doubt reduce economic activity, particularly in very sensitive sectors like housing and autos. Agriculture where borrowing is necessary will also be harmed.

The Fed seems to think that inflation is likely, but the facts do not bear this out. Inflation is under better control now than it has been for decades. The Producer Price Index has only increased by six-tenths of a percent over the last year. The figure that came out on Thursday for July showed a substantial increase, 0.5 percent. But almost all of that was due to two things: Fuel, partially caused by an oil strike in Nigeria; and food, largely caused by a huge increase in the cost of coffee, which rose by 22 percent. This rise in coffee prices accounted for four-fifths of the increase in food inflation. But poor coffee crops do not mean generally higher inflation. Crude goods actually dropped by 0.9 percent in July.

Another key indicator, the Consumer Price Index, has increased only 2.7 percent over the past year. Wage increases, which could be the greatest threat to serious inflation, if it ever should occur, has risen a paltry 0.4 percent adjusted for productivity.

In other words, inflation is under control. While we are seeing certain specific commodities with significant price increases—I mentioned coffee and oil—real inflation is lower now than it has been in decades.

I think the second point that the Federal Reserve is overlooking is that the economy is slowing down. Cyclical industries are already showing serious softness because of earlier Federal Reserve actions. New housing starts have been moving down since the Federal Reserve started increasing rates in February.

Mr. President, this is the fifth increase in interest rates by the Federal Reserve Board since February. And what has been happening? Housing starts are now 6.8 percent below their March level. Auto sales are soft. The unemployment rate rose to 6.1 percent last month. There are over 8 million people counted as being unemployed, 4.4 million people forced to work at part-time jobs due to unavailability of full employment and large numbers who have left the job market altogether because they have given up.

The argument by some that we must dampen down the economy now to avoid the possibility of future inflation does one thing. It guarantees a sure loss in jobs and growth in order to assure that the smallest possibility of inflation is wiped out.

But the cost to our economy is great. Some say that the bond market is only happy in a recession. Well, it appears to me that the chairman of the Federal Reserve system is happy only when the bond market is happy. I might be a bit too strong, but I think it is correct. What they are looking for is the effective elimination of all true inflation but to achieve that they are almost willing to have the economy in a continuous stall, and that is what we are coming into right now.

So what are the economic and social results of the Federal Reserve policy? Well, if you are in the bond market, it is great. But if you are an average American working hard to try to raise your children, you are worried about losing your job and no growth in income. In fact, you are probably losing ground. Your ability to buy a house has been sharply reduced.

A 30-year conventional mortgage has risen by about 1.5 percent since February. If you have an adjustable-rate mortgage, your monthly payments are going to go up $100 to $150 a month compared to the rate based on February's interest levels. That hurts working families. If you are a farmer with significant loans to cover the cost of buying materials you need to feed your hogs or other livestock, your interest rates will rise and your profits will shrink. That is the real world out there. That is what is happening.

The bottom line is that the Federal Reserve has taken action which is clearly not in the Nation's interest. They have decided on a very narrow agenda, effectively captured by the narrow interests of the bond market rather than balancing the bond market's needs with that of the Nation as a whole.

Plain and simple, Mr. President, the Federal Reserve Board is out of touch with ordinary Americans and what is happening in our economy. This is something that needs to be talked about further.

I will close with this, Mr. President. In a recent article in the Washington Post, the writer, Jim Hoagland, made these points. He said:

> One man's job is another man's basis point in the brave new economic world of the central bankers.
>
> Being unemployed may be bad for you, but cheer up. It cools inflation, and should be good for the markets. That is part of the unspoken and unspeakable philosophy that lies behind the manipulation of interest rates in the world's leading industrial economies in recent months. Because of the central bankers' abiding and unbalanced fear of inflation, declining unemployment rates have become a hair trigger for raising interest rates.

Mr. Hoagland went on to say:

> The bankers and fund managers resemble old generals refighting the last war after the battlefield has changed. They build an imaginary line of high, long-term interest rates instead of adapting monetary policy to a world in which the greater barriers to economic renewal are unemployment and the lack of public investment in productive enterprises.

Mr. Hoagland closed by saying:

> Growth is measured in jobs, as well as in stock and bond prices. Low inflation rates purchased by high unemployment will turn out to have been a very dubious bargain.

Mr. President, I did not mean to interrupt this ongoing debate about health care, but I do believe that the action taken by the Federal Reserve Board earlier this afternoon is going to further stall our economy, further raise interest rates, and create higher

unemployment than we would otherwise have out there. It is going to start slowing this economy down even more, and I do not believe the Federal Reserve Board really had the basis for raising those interest rates, once again—five times since February.

Mr. President, I have been supportive of the independence of the Federal Reserve Board. But I think we have to get some people on that Federal Reserve Board that really understand what is happening to ordinary working Americans out there. Their action today is going to hurt people. It is going to cause working families to have a reduction in their income and their standard of living.

It all may be lost in the debate on health care that is going on here right now. But I did not want the afternoon to pass without at least one Senator getting up and challenging the Federal Reserve Board on the actions they took today because I believe the actions they took will truly hurt the working Americans.

Mr. MOYNIHAN. Will the Senator yield for one question?

Mr. HARKIN. Yes.

Mr. MOYNIHAN. Knowing the standards of courtesy and integrity which he embodies, I wondered if he would not want to modify the remark about the Chairman of the Federal Reserve which could be taken as personal. Dr. Greenspan is a person of deep, utmost integrity, of great learning, and a genuine concern for what he thinks is best for the American economy. He would not have any partiality to bondholders any more than to stockholders. The concern about inflation has sort of for half a century been a concern of the successive Chairmen of the Federal Reserve. No one had to deal with it more dramatically than the predecessor in 1982 who had to bring us into a deep recession because we had gotten to the point of double-digit inflation. That was a dramatic act. We would never want to see that repeated. So we would never want to see a situation where it was necessary.

Mr. HARKIN. If the Senator will yield, I said in my remarks that "it seems"—I will check the RECORD. But I said "it seems" to me that the Chairman of the Fed is only happy when the bond market is happy. I said it appears to be.

I do not deny that Mr. Greenspan—I did not use his name. But he is the Fed Chairman. I do not know him personally. But I understand that he is a man of high character, high integrity. I accept the judgment of the Senator from New York.

Mr. MOYNIHAN. He is surely that.

Mr. HARKIN. I accept the Senator's judgment on that.

Obviously, I do not know him personally. I am just looking at the record of what has happened since February. I do not believe that what is happening in our economy warrants five increases in the interest rates from, I think, if I am not mistaken, 3 to 4.75 in the Federal funds rate since February. I think it bodes ill for our economy. I think that perhaps the Federal Reserve Chairman, perhaps others on the Federal Reserve Board, have too narrow of an approach in looking at our economy.

I think we have to understand some other things going on in our economy other than just the possibility of future inflation. I do not believe the Senator from New York means to say that the present situation that we have encountered over the last 18 months at least, perhaps even 2 years, is in any way near what we were facing in the late 1970's.

Mr. MOYNIHAN. No.

Mr. HARKIN. Or eighties. We are not anywhere close to that. I said we do not have serious inflation out there, to speak of, right now. Yet, because there is a possibility that at some future time we might see inflation going up—Federal Reserve action is taken to raise interest rates. I am just making the point that this is not something that just takes place in the financial pages of the Wall Street Journal. It has real effects on working people throughout this country.

So I apologize, and I do so if my words cast any aspersion at all upon the character of or the integrity of the Chairman of the Federal Reserve Board. It is not my intention to do that. I do not mean to do that. I just meant to say that I think his focus has been somewhat too narrowly focused just on the bond market, and it ought to have a broader focus than that. But, no, I did not in any way mean to impugn his integrity or loyalty to his country or anything else. But I think the Fed needs to take a broader view of the economy.

Mr. MOYNIHAN. I thank the Senator.

Mr. D'AMATO addressed the Chair.

The PRESIDING OFFICER. The Senator from New York.

Mr. D'AMATO. Thank you, Mr. President.

HEALTH SECURITY ACT

The Senate continued with the consideration of the bill.

Mr. D'AMATO. Mr. President, I do not intend to speak for hours in an opening statement on health care. But I do intend to reflect my feelings and those of an overwhelming number of my constituents in New York, at least those who have taken the time to call my office or write to us either here in Washington or in one of the offices that I have throughout the State of New York.

I think, Mr. President, that there probably is no area that is more important than the area of health care as it relates to each of us individually, as it relates to our families, as it relates to the American people. It is an area that no one can doubt needs reform. We need to improve it. But despite its flaws, it is still the best health care system in the world, bar none, the best. I daresay that if the poorest of the poor in this country had a problem, they would get better medical treatment here than Boris Yeltsin gets in Russia. Indeed, if Boris Yeltsin had a severe medical problem, he would probably come to this country, if he could, to get medical treatment.

So let us not take that choice away from Boris Yeltsin. More importantly, let us not take that choice away from the American people.

I have a piece of advice because I have been hearing a lot of people offering advice. I say to the President and to the First Lady, passing bad legislation that the American people do not want is not good politics, and it is not good government. Take it either way. It seems to me that what is taking place—at least that is the feeling that I get—is that some would have us act such that we would not make corrections that we all know need to be made, and not improve the system that we know can and should be improved. But, no, they say you must take the whole thing. Otherwise, we will accuse you of playing politics. Otherwise, we will say that you are holding captive this important piece of legislation.

I say we were not sent here by the people to surrender good judgment on the altar of political expedience, or under threat of being kept in session around the clock. We were sent here to work to bring about a better system if possible, but not to destroy the best system that exists in the world.

Less than 2 weeks ago, we got our first look at Senator MITCHELL's health reform package.

That was a bill of some 1,410 pages, 46 pages longer than even the 1,364-page Clinton bill. That was less than 2 weeks ago. The ramifications in that legislation—and it is voluminous—reach right into everyone's home. And the people have a right to know, how does this legislation affect them, and how does it impact the plan that they have at the present time? The people have a right to real answers.

I daresay that there are many of my colleagues who do not have those answers. I do not have all of the answers. I am still learning.

That was 2 weeks ago when the first bill was placed on our desks. Then when I checked my desk Wednesday, I found that the bill had grown, and this new bill—call it Mitchell 2—was 1,448 pages long, 84 pages longer than the Clinton bill. And, yes, on this Saturday we were presented with the third Mitchell bill, 1,443 pages long, actually 5 pages less than the second one. There is a rumor that there may be Mitchell 4; I do not know. But I do know that we

cannot implement 1, 2, or 3 without doing significant harm to our American health care system and the American taxpayers. I do know that it is a flawed bill, deeply flawed.

Whichever bill you choose, the result is the same: More taxes, more new entitlements, and much more Government intrusion into our health care system.

Mr. President, I do not intend to tie up my colleagues on the floor, but I think these things have to be said. I do not intend to speak for 2 or 3 or 4 hours on this. This is not an attempt to impede, but it is an attempt to educate. I have to tell you that as the days go by, more and more people call, and some call and say: You know, we want there to be changes, but we want you to do it the right way. Do not just rush this through. Take your time. That is what the sentiments of these people are, and it is the gist of the numbers which I am going to share with you in a little while.

This bill contains hundreds of billions of dollars in new taxes—taxes that could have a devastating impact on middle-class America, taxes and costs on existing health plans that go well beyond what people have ever imagined. Let me just cite two of these new taxes. There is a 25-percent tax on health insurance premiums that grow faster than a premium cap. Who establishes this cap? Some board on some vague principles that no one knows about. If you turn to page 1170, section 4511(a)(1), it states:

If a community-rated certified standard health plan is a high-cost plan—

I do not know what this high-cost plan is. It very well could be that the plans most people have would be rated high-cost.

for any coverage period beginning after December 31, 1996, there is hereby imposed a tax equal to 25 percent of the excess premiums of that plan.

Mr. President, this tax could force millions of Americans to pay more taxes on the plans that they have already chosen. That is not me saying this. That is the Congressional Budget Office. They say:

Virtually all plans would be subject to the assessment called for in Senator Mitchell's proposal.

The words have meaning. We are talking about something of some tremendous significance. So someone who has worked and has bargained and who has achieved a plan that in December 1996, may be considered to be one of these so-called high-cost plans, finds him or herself in a situation where their premiums are raised 25 percent. Let me suggest that all the legislation in the world that says the insurance company cannot pass the cost on is not worth anything. Do you mean to tell me that you are going to raise a tax of 25 percent on the excess of that part that you say is too rich? Since when should people be penalized for buying health care insurance, whether or not they have bargained for it, that is excellent and fully comprehensive.

I thought this was the United States of America, where people had the right to invest in those plans that would give to their families the best protection. Now we are going to penalize them. It is absurd to say that insurance companies are not going to pass that extra cost on and, indeed, some insurance companies, in order to beat that, will raise their costs between now and December 1996. This tax will apply regardless of the reason the plan was considered high-cost. But it is most likely to affect desirable plans which seek to provide the highest quality benefits and the broadest choice of providers—or those that cover the sickest individuals.

I cannot understand that. That is under the name of cost containment. That is Government regulation at its worst. If we want to get ourselves into deep trouble, let us adopt this kind of philosophy. We could be debating this principle alone, and its cost and implications, for days, and for anyone to suggest that we adopt this whole thing, take it or leave it, within a period of hours, days or weeks, is simply wrong. That is not why we were sent here. Take it or leave it, or we are going to keep you in like little children. You will not be able to go home. So what, that is our job. Are we supposed to be cowed by that and ignore our rights, and ignore the fact that we were elected to come here to look at these provisions, to examine them? These are important, these are critical, these are life and death issues.

I suggest to you that any plan that is so important to the life and health of the people of this country should never have been designed in a back room with the 600 people in the task force that came together, without the benefit of real, comprehensive hearings, and without the benefit of a full examination of all of the details that are critical to the life of this country and its people. I think it would be a political charade if we pushed something through for the sake of saying we pushed it through. That is politics and government at its worse.

CBO estimates that this tax would cost American taxpayers $70 billion over a 10-year period of time. Just that 25 percent tax. I have to tell you that if you look at CBO estimates, if you look at what they estimated the cost of Medicare would be, you would find out that it has increased about seven times more than their original estimate. It was seven times more. I do not know whether this is going to be $70 billion. It is certainly not going to be less than $70 billion.

Here is another tax. There is a 1 percent tax on health insurance premiums levied by the State to fund "administrative expenses." That only amounts to $50 billion. We take that tax and the other taxes levied in this bill and we come out to a total of over $300 billion in new taxes.

Then again when we have people say, "Oh, well, do not worry; Government can do it better, faster, more efficiently, and more effectively." On what planet? That must be a planet I am not aware of. That is certainly not true in this country, and I know of no other country on the planet where it is.

This bill creates and empowers dozens of new Government bureaucracies.

And there is one in particular that would have devastating consequences for my home State of New York, one which the senior Senator from New York, Senator MOYNIHAN, eloquently addressed—a new Council on Graduate Medical Education. We are going to take a bunch of bureaucrats, and they are going to determine for us how many doctors we should have and what their specialty should be.

I wonder who it is going to consist of. Will Hillary be on that council? Will she tell us how many thoracic surgeons, how many specialists there will be in various specialties? Incredible. We are now going to micromanage the health of America so that the Federal bureaucrats will determine who the specialists in America will be and how many. Fabulous. Fantastic.

They even had a hard number in their original bill. They effectively said that you are going to have to eliminate right off the bat in New York over 3,000 residents, specialists who come in and get the best training, specialists who, by the way, are dispersed throughout this country and through parts of the world.

Let me tell you what this would mean. New York trains 11 percent of all the country's medical students and nearly 16 percent of the medical residents. Imagine. They have already determined—and I do not know where or how this was determined—that they are going to reduce the total number of medical residents across the board by one-fifth, and that results in a loss of 3,000 medical residents in New York City alone.

Well if we are going to talk about Government deciding how many specialists we are going to have—how many cancer specialists, how many heart specialists—do you not think that we should have some thorough and comprehensive debate as to how this is—testimony not from politicians, but from leading educators, from people in the field, as to whether or not that is an idea we should even contemplate? Do you not think that would be deserving of some kind of introspection, some kind of close examination? And I do not mean on the floor of the Senate with no facts, with no basis by which to make our judgments. This procedure is an absolute sham. We

should not be proceeding on this bill in this manner.

I have just touched on two items, and they are pretty doggone important to the health of this country.

And there are thousands of items that are as critical if not more critical jammed into this bill that affect the lives of every American. That is why Americans are on the telephone and why they are calling. And I have these numbers I will submit as a representation of the calls that have come into our office from August 8 to August 16 up to 12 o'clock.

New York City, against implementing a health care bill this year—by the way, most of these people have expressed that they want reform, but they say do it right, do not rush it this year, wait until next year, and then go ahead—against, 475; in favor of going ahead and enacting the Mitchell bill, 291. Even in New York City the ratio is clearly 3 to 2 against going forward.

Rochester, NY, 162 against; 12 for—14 to 1 against going forward.

Our Washington, DC, office—and most of these people call from New York City—691 against; 258 for going forward, almost 3 to 1 against going forward.

Albany, NY, 190 against going forward; 25 for going forward, a ratio of 7.5 to 1 against.

Buffalo, 563 against going forward and adopting this bill.

I tell you if we began to examine this bill in the kind of detail that we should in terms of discussing just some of the issues that I have brought up here, you will find these numbers will go off the chart, and I will assure you that this Senator will look to discuss, even in as limited and circumscribed a manner as this body prescribes, that we examine the issues, that we examine them. They are too important just to be shoved through without debate.

Syracuse, 452 against to 35 for, a ratio of 13 to 1 against.

All in all, it is almost 4 to 1 against, 2,534 to 750.

Mr. President, I ask unanimous consent to have printed in the RECORD, the tally of health care calls with reference to the Mitchell bill.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

HEALTH CARE CALLS IN MITCHELL BILL: 8/8–8/16, AS OF 12:00 PM

	Against	For	Ratio
New York City	475	291	1.65:1
Rochester	162	12	14:1
Washington, DC	691	258	2.7:1
Albany	190	25	7.5:1
Buffalo	563	129	4.4:1
Syracuse	453	35	13:1
Total	2,534	750	3.5:1

Mr. D'AMATO. Mr. President, as I have said, the loss of these residents to New York will have devastating consequences on New York, but it is also devastating to the Nation when one stops to think that we train almost 16 percent of the medical residents in this Nation.

It would cost us 3,000 residents. I tell you that the cost would be incalculable as it relates to the quality of medical care in the New York urban area. The financial cost alone would be well over $500 million. The quality of care that our people would have would diminish tremendously just in this one area.

Mr. MOYNIHAN. Will the Senator yield for a question?

Mr. D'AMATO. Certainly.

Mr. MOYNIHAN. When the Senator speaks of a resident in a hospital, he is talking about a doctor?

Mr. D'AMATO. Correct.

Mr. MOYNIHAN. The doctor.

Mr. D'AMATO. Fully certified doctor who is getting his specialty—his training—and some going on into the specialties. And so we would be taking out—and I thank my colleague for making the point—3,000 fully trained doctors, some of them working in their specialties. We would be removing them from servicing the needs of the urban poor. It has been estimated that to replace them would cost somewhere in excess of $566 million annually in New York alone. You would have the same kinds of consequences in other key centers throughout this Nation.

Again, I would emphasize the absurdity of thinking we are going to turn it over to a Federal bureaucrat or a board to determine how many doctors in the various specialties there will be. Have we not ever learned about the law of supply and demand? While the rest of the free world is looking to come to a market-oriented economy, here we are moving in the other direction, with Big Brother determining the allocation of medical specialists in our Nation. We are not talking about plumbers and carpenters and saying maybe we have to increase the emphasis on them in our trade schools. We are talking about life and death matters. We are talking about people who want to dedicate themselves to the service of others. And some bureaucrat is going to determine this.

Mr. President, the Federal Government, to be parochial, does not have the right to tell New York, or any other city for that matter, how to run its medical schools and teaching hospitals and does not have the ability to do that. I spoke to Dr. DeBakey, the great surgeon, the great pioneer at Baylor College of Medicine in Houston, and he absolutely could not believe it and made reference to what a blow this would be to science and to medical care if we were to attempt to implement this. By the way, this board's decisions would be final. They are the arbiters.

Mr. ROCKEFELLER. Will the Senator from New York yield?

Mr. D'AMATO. No; I will not. I have been waiting for days and days. I am not going to speak for hours. I want to make my point.

Young Americans who grow up wanting to be doctors should not be told by a Government bureaucrat what career they will be placed in. They should not be told we have too many doctors in this specialty or that specialty. If they want to try to make it and they have the ability to make it, then they have the right to try. There is something called the law of supply and demand.

Government bureaucrats should not have the right to tell any American what health plan is best for them, and that if you have one better than the standard benefits package we are going to assess you, we are going to tax you for it, you are going to pay more for it. The American people do not want a Government-run health care system. They want Congress to fix what is broken and to leave alone what is not. And we have an obligation to fix what is broken.

We can easily identify it, and we have. But for some reason, we do not want to just fix that which is broken. We want to go beyond. We can fix what is broken by enacting commonsense reforms that Members of both parties already agree will help solve the biggest problems in our health care system, reforms like portability, so those who move or change jobs can take their coverage with them; insurance protection, so people with preexisting medical conditions will not be denied coverage and those who fall ill will not have their coverage dropped; and tax reforms. My gosh, why should someone who is self-employed lose the ability to deduct his cost if we say that is an essential part of America? Let us do that. Let us give small businesses and individuals the same tax relief for buying health insurance as people with employer coverage. It is common sense.

But, no; some people want to create a political campaign, a political storm, and say we are going to fix it all; you are going to take it all whether you like it or not, whether you have a good health care plan or whether you do not, because we know what is good for you. What the American people do not want, is for us to adopt the Mitchell bill—or any bill—for political reasons. No bill should be adopted for political reasons. No bill should be stopped simply for political reasons. Congress should not pass a bill simply to pass one. That is wrong. And that is what the American people are telling us. They are saying take your time and do it right.

If I have to come down to this floor as we proceed, and go through section after section, not to nitpick but to raise issues that are critical, it is my obligation to do so if I see we are just determined to ram this bill through. That is not a filibuster, and it is not intended as one. But it will be intended to explore and to develop all of the

facts. I suggest this is the wrong forum to do it. These matters should have been gone over in detail.

I know the Labor Committee had their hearings. They did not go over these things in detail. I say to my learned colleague, the chairman of the Finance Committee, some of these provisions have to be new to him and he, too, has to be very concerned about them. We all should be.

This is just the tip of the iceberg. Tomorrow I intend, for a short period of time, to come down to the floor and touch on at least one other critical area. We are talking about the health of the people of this country. People do not want us to abdicate our responsibilities.

I broke my shoulder in three places. I was able to pick the best doctor, and thank God he did not have a bureaucrat who determined whether or not he could or could not go into his specialty. That is the last thing we need. When my dad had an open heart procedure—fortunately, it was an angioplasty—we picked the doctor. He had an insurance plan he subscribed to. He went to the hospital of his choice. Americans should have that right. No one should lose the ability to pick their doctor and the hospital of their choice because we allowed Big Brother Government to say, "Oh, no, that is too good a plan."

I hear about this great Canadian plan. Is that why so many people come over to use the hospitals in Buffalo, because they do not want to wait 6 months, 8 months, a year, a year and a half, for some of the optional services that here in this country our people get when they are sick or in pain? Are we going to have a bureaucrat say, "Wait a minute; we cannot do any more hip replacements"? Is that what we are talking about?

Let me share two letters that have come to me, one dated August 8 from a constituent from Honeoye Falls:

DEAR SENATOR D'AMATO:

The thought of a health bill being pushed through the Congress in the next two weeks sends shivers through my spine. How can you people digest the huge amount of information being stacked before you and make a responsible decision on what is best for the people of America?

I want to know what is being promised in the various bills, what it will cost, who will be covered, how will it work, who will pay for it, how it will affect the health coverage I already have . . .

I want you to know that is the dominant thing so many people call about. They say: I like my health care coverage. I want to continue it.

I urge you to wait until we know all the answers to these questions before considering such sweeping changes to the American health care system—1995 is soon enough!

Sincerely,

ELINOR W. FISK.

I ask unanimous consent a copy of this letter be printed in the RECORD.

There being no objection, the letter was ordered to be printed in the RECORD, as follows:

HONEOYE FALLS, NY, *August 8, 1994.*

Senator ALFONSE D'AMATO,
U.S. Senate,
Washington, DC.

DEAR SENATOR D'AMATO: The thoughts of a health bill being pushed through the Congress in the next two weeks sends shivers through my spine. How can you people digest the huge amount of information being stacked before you and make a responsible decision on what is best for the people of America?

I want to know what is being promised in the various bills, what it will cost, who will be covered, how will it work, who will pay for it, how it will affect the health coverage I already have, why the whole system has to be changed.

I urge you to wait until we know all the answers to these questions before considering such sweeping changes to the American health care system—1995 is soon enough!

Sincerely,

ELINOR W. FISK.

Mr. D'AMATO. I have another very short letter from Laurrie Brinckerhoff, 15 Charles Street, New York, NY.

Please! No Health Care Plan should be rushed through the Senate this year. If there is a plan, we need a carefully studied and well thought out plan.

Sincerely,

LAURRIE BRINCKERHOFF.

Mr. President, passing any bill without the public's informed consent is not good government. It is not good health care. It is not responsive to the will of the people. We are pushing this piece of legislation through at this time, and there is that momentum behind it, because of the political ramifications. That is wrong. The American people are telling us take your time. They are telling us do it right. They are telling us they want change. But they want it done the right way.

I think as people listen to the debate and to the areas of concern—not just amendments that are put forth, but the various areas of concern and the ramifications that this legislation contains—they will say resoundingly, "Don't just push it through." That is exactly what is taking place here.

I thank my colleagues and yield the floor.

Several Senators addressed the Chair.

The PRESIDING OFFICER. The Senator from Delaware.

Mr. BIDEN. Mr. President, I rise not to speak to the health care debate, but something else that is impacting on the health care debate. One of the problems on the health care debate is that a lot of people engaged in the debate either have not been around or paid attention for the last 2 years that we have been discussing the health care problem, or have not paid any attention to the committees in question that have held probably hundreds of hours of hearings, all told, on the problem, and now stand and wave around a bill as if this, whatever number of pages it is, is something that was dropped from heaven or come up from hell, and that they have never seen before.

The criticisms made of this bill in the generic form could be made about every piece of major legislation that ever passed through the Senate. I remind my colleagues who have had no problems voting on major communications legislation, major legislation relating to anti-trust measures, major legislation relating to a thousand other areas—the Clean Air Act, the Clean Water Act—larger than this. They could have said the same exact thing. That is why we have a committee system. That is why we have the staffs we have. That is why we are supposed to pay attention. That is why we are supposed to understand some of what has been done. But it astounds me how little is understood by people who engage in this debate—and I am speaking of no one in particular—but how little is understood. I will just say one thing to my friend from New York. He is my friend, as we say. He and I truly are good personal friends. He gave the example of his father wanting to be able to choose his own doctor and wanting to be able to choose his own hospital.

I think that is a phenomenally important right, whether we pass health care or not. The vast majority of Americans do not have that chance. If they work for major corporations, the corporations decide, and by the time this decade is over, I predict there will not be any plans that allow that. They will all be HMO's with preferred providers. They are coming along.

Just look at all the people in Washington today, the people who are in the galleries, in this city, and the people listening to this debate. I ask you: How does your employer change yours—if you are lucky enough to have health care plans—how have they changed those plans in the recent past? I happen to have chosen a plan that does not. I am not in an HMO. HMO's are cheaper. You can spend less money if you want to be in an HMO. The point is, a lot of this is changing whether or not we do anything at all, and a lot of the choices the Senator is worried about are going to be eliminated if we do not do something.

I will not take the time to discuss it now, but I have a summary of responses that have come into my office—I am from a very small State, unlike a large State like New York. New York literally has counties bigger than my State and New York City has a population that is probably somewhere around 13, 14 times as large as my entire State.

But roughly 7,000 people have written to me in response to a series of questions I asked them.

Mr. President I might point out, the answers have come to very different conclusions than the 2,200, or thereabouts, phone calls my friend from New York who represents a State with—what?—18, 19, 20 million people in it? I would not call those calls particularly representative.

CRIME BILL

Mr. BIDEN. Mr. President, one of the things that the health care debate is reflecting is the same kind of, in some cases, nonsense that the crime debate is generating. I think that in this town, if you say something often enough, repeat it often enough, people actually begin to believe that it might be true, if you just say it.

What I have learned of late when the House failed by a margin of eight votes to pass the crime bill on a technicality; that is, they did not even allow a vote up and down, as they say, for or against the crime bill. They had a procedural vote to hide the "no" votes so they would not have to say I am against it for politics or I am against it because I am against assault weapons being eliminated, roughly 19 of them. It was a procedural vote, not unlike a cloture vote we have in the Senate.

What I have heard in the last week about what is in this crime bill and the conference report I find truly astounding. I doubt whether there is anybody on the floor of the U.S. Senate—it does not mean I am any better, but I am stating a fact—anybody who has put as much time and effort into fashioning these crime bills over the last 20 years, the last 6 in particular, than me. I have a distinct disadvantage and advantage. The disadvantage is I have done nothing but this issue, it seems, for God knows how long it is. The advantage is I think I know as well as anybody what is in the bill and in great detail.

So for my colleagues who are acting in—and I always assume my colleagues act in good faith, who truly believe some of the stuff that they have heard and said, and this is the purpose of my rising now to sort of set the record straight and lay out the facts. I am not sure it will change anybody's mind, but I just think it is important that when one is against something, they have the right reasons; that is, they know what their reasons are for being against something.

Let us start off with pointing out what the bill is. It sets up a trust fund with no new tax dollars—no new tax dollars; no new tax dollars to fund this. You say, how could that be? We are going to spend $30 billion over 6 years and no new taxes.

The real issue is whether or not we reduce the deficit by $30 billion or spend the money on crime prevention and crime enforcement, law enforcement. That is a legitimate debate. But this red herring out there that this is going to cost $30 billion in new taxes is simply wrong.

Let me tell you how we fund the bill, again. All of you know this because you helped put this together. We voted this 95-4 when we voted it out of the Senate. The way we fund it is, we trade bureaucrats for cops, bureaucrats for prisons, bureaucrats for law enforcement, bureaucrats for drug treatment in prisons, while someone is locked up in prison, bureaucrats to fund the violence against women initiative.

You say, what does that mean? What we did, what this President did and we codified, we said we are going to reduce the Federal work force by over a quarter of a million people over the next 6 years. I might point out, by the way, that under this President there are fewer Federal Government employees today than at any time since John Kennedy was President. It rose under every Republican and every Democrat prior to this. This President has actually reduced the number of people working for the Federal Government.

We are going to reduce it by a quarter of a million people more. We cannot spend this money for crime until we fire or we do not rehire someone or fill a position. So what happens here is this savings, to use the Senate jargon, has been scored. We talk about OMB, the Office of Management and Budget, and we talk about the Congressional Budget Office, which means nothing to the voters at large. What they are is a bunch of bureaucrats sitting there with sharp pencils and computers and deciding whether or not what we say is savings or not savings or actually real dollars. Are they real or are they phony?

All of the organizations have pointed out—Democrat, Republican—everyone acknowledges that this is an actual savings that will occur by reducing the Federal work force, which we have already done in the last 2 years and will continue to do. Unless we reduce the Federal work force, we cannot increase the police force. Unless we reduce the Federal work force, we cannot increase the prison space. Unless we reduce the Federal work force, we cannot increase the number of drug courts, and so on.

So if my Republican friends want to stand up and say—which is totally legitimate—"Look, JOE, this bill you all put together and that I voted for before and I might not vote for now, this bill, instead—I have thought about it—instead of setting up a trust fund to take the savings that come from firing or reducing the Federal work force and put it in a trust fund to hire cops, instead of doing that, what I would like to do is take the savings from firing or reducing these Federal workers and I would like to reduce the Federal deficit even more"—I might add, by the way, this is the only President who has reduced the Federal deficit in the last 2 years. The Federal deficit has actually gone down. That is, the amount of the deficit that was projected, it has gone down. It is less each year under this President than anyone had predicted and less than under the Republican Presidents, and it is going down.

If they say we want it to go down even further, and we do not want 100,000 more cops, I respect that. That is OK, you can say that, then go to the voters and say, "I rather the deficit be down lower and not hire more cops." That is fair. That is honest.

Or if you say, "BIDEN, you have money in here for the operation, maintenance, and construction of over 105,000 new prison cells in the various States—not Federal prison cells—State prison cells. I do not want to spend the money for that, BIDEN. I want to go out there and reduce the Federal deficit over 6 years by $6.5 billion," well, that is fair. Let us debate that and let us let the people in our home States decide whether we should reduce the Federal deficit by another $6.5 billion or let us spend the money to build 105,000 new prison cells and maintain them.

That is a legitimate debate. But it is an illegitimate debate to suggest, and it is factually not true to say, this bill that BIDEN and others cobbled together is going to raise taxes $30 billion beyond what we are now paying. Not true. Not true.

So the first important point about this crime bill—and I see the chairman of the Appropriations Committee is on the floor. This trust fund was something that really was his idea. I was not smart enough to think about it. He is the smartest guy in this outfit. Truly. I am not being solicitous. He is. And he is the best legislator in this outfit. He is the guy who thought of this. I did not think of it. I wish I could take the credit. I did not think of it.

But this is not $30 billion in new taxes. This is $30 billion we are not going to reduce the deficit by and spend it on law enforcement. That is true, but it is not $30 billion in additional taxes.

(Mr. BYRD assumed the chair)

Mr. BIDEN. Now, the second point, in this bill over 6 years, for law enforcement there is $10.7 billion for local law enforcement and community policing. Not Federal cops. We go to the States and say we are going to give you x number of dollars if you do two things. No. 1, if you do not cut the number of local police. As the Senator from West Virginia, the President of the Senate, knows, we used to have a thing called LEAA, Law Enforcement Assistant Program, out there.

What we found out the States did, we would send the money, and States, to try to make their budget look better, and counties—and I used to be a county official. I remember when our county tried to do this. If you had 100 county police officers, you would go out and you would fire 25 of them, take the Federal money and hire them back with the Federal money. Then the States and localities would go to their taxpayers and say: You see how responsible we are. We cut your taxes. Those big-spending guys down in Washington. And we still had the same number of police.

We got smart to that down here. So in this bill we said, look, you want 1 new local cop paid for by the Federal

Government, if you now have 100 cops at home, if you reduce it by even 1, you do not get any Federal money. But if you maintain—maintenance of effort—if you maintain the 100 cops you have, we will give you money for more cops.

There are roughly 545,000 State and local police in all of America. This bill will add 100,000 additional local police. So you will have almost 650,000. We will increase by roughly 20 percent, a little less than 20 percent, the total police force in all of America that is not Federal.

The reason we know that is you do not get any money if you reduce your police force, if you do not maintain your effort. We are making a promise to the people back home. We are going to put more cops on the street. This is called truth in legislating.

Now, if you local folks back home do not want the money, do not ask for it.

My Republican friends say, well, there are strings attached to this money. Strings, malarkey. Nobody has to come and ask for this money. But if they ask for the money, I say to the Presiding Officer, they have to do two things. Promise, No. 1, that they are not going to fire their existing police force, and, No. 2, that they take all their police, not just the ones we are adding for them, but all their police and involve them in community policing so they are not just in squad cars, so many more are walking around on the beat, because, guess what?

Those of you from Houston, TX, those of you listening who are from cities like New York City, and all the places where they have done community policing, the violent crime has dropped roughly, in Houston by 19 percent.

This is not rocket science, folks. There are some things we know about crime. We know that if there are two street corners in the same city, one has a cop standing on the corner and one does not have a cop, the chances of a crime being committed where one has a cop is less than the one where there is not a cop. Again, not rocket science. Cops prevent crime as well as arrest perpetrators of crime.

So we are basically, I say to the Presiding Officer, getting a big bang for the buck. For the 100,000 cops we are providing, we are leveraging that to get 640,000 community police out there. Right now, of the 550,000 cops, there are perhaps 100,000 involved in community policing.

So that is a string. That is right. If you want the money, then what you have to do is you have to have your police in community policing.

Now, there is another criticism I hear from our Republican friends, who I might add all voted for this—all voted for this before. I do not know what happened between now and the time this will hurt the President if you vote against it. I do not know what strange thing happened. But they say, "Well, wait a minute. Is it not true after 6 years, BIDEN, the city or the county or the State is going to have to pick up the tab for this police officer?"

That is a condition? What is every other program? Are my Republican friends saying we should federalize the local police force? Does any one of them have an amendment with which they are going to stand up here and say, "I promise from this day forward we in the Federal Government will fund every local cop now and forever." Does that make any sense?

What do we do in every single program? There is a program out there now that started last year. It is $150 million in supplemental money to help local communities buy additional police officers. It is only, roughly, a 50–50 grant. They are falling all over themselves to come and say, "Please, you will pay for half a new cop for us." Wonderful.

It only lasts for 3 years. This lasts for 6 years, and it is $75,000 per cop. How are we hurting the communities by doing this?

When I was a young student in law school, I remember a professor saying, "Well, that's a red herring." I thought, "What is a red herring?" I thought a red herring was a fish or something. Well, these are not red herrings. These are things that do not have anything to do with the merits of the subject. These are smokescreens.

Now, what else is in this legislation? I can see my friend from West Virginia is standing up, so I am going to not go through all I was going to go through because this really should be a health care debate, but there is so much out there being said, I say to the Presiding Officer, that is simply not true I feel I have to say something now so at least I can engage my Republican friends in a little truth in debating as we go down the road.

What are the major arguments used against this bill?

I ask unanimous consent that the totality of all that is in the crime bill conference report broken out in terms of how much is spent for each item be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

SUMMARY OF CRIME CONFERENCE REPORT

TOTAL TRUST FUND DOLLARS—$30.2 BILLION

Provides $30.2 billion over six years through the Violent Crime Reduction Trust Fund. Savings from the President's reductions in the federal workforce, as calculated by the Congressional Budget Office—and locked in by reductions in the budget caps—will fund $30.2 billion in crime bill initiatives as follows:

LAW ENFORCEMENT—$13.2 BILLION

State and local[1]—$10.7 billion, including:

Community Policing: $8.8 billion to put 100,000 police officers on the streets in community policing programs.

Rural law enforcement: $245 million for rural anti-crime and drug efforts.

Technical automation: $130 million for technical automation grants for law enforcement agencies.

Brady bill: $150 million for Brady bill implementation.

Drug enforcement: $1 billion in Byrne formula grants.

DNA: $40 million for DNA testing research and programs.

Courts, prosecutors, and public defenders: $200 million.

Federal—$2.6 billion, including:

FBI: $250 million.

DEA: $150 million.

INS and Border Patrol: $1 billion.

United States Attorneys: $50 million.

Treasury Department: $578 million.

Justice Department: $300 million.

Federal Courts: $200 million.

PRISONS—$8.3 BILLION

Grants to States: $6.5 billion to states for prisons and incarceration alternatives such as boot camps to ensure that additional prison cells will be available to put—and keep—violent offenders behind bars. 40% of monies to be set aside for states that adopt truth in sentencing laws.[2]

Alien Incarceration: $1.8 billion to states for the costs of incarcerating criminal illegal aliens.

CRIME PREVENTION—$7.4 BILLION, INCLUDING:

Ounce of Prevention: $100 million to create an interagency Ounce of Prevention Council to coordinate new and existing crime prevention programs.

Community Schools: $630 million for after-school, weekend and summer "safe haven" programs to provide children with positive activities and alternatives to the street life of crime and drugs.

F.A.C.E.S.: $270 million to provide in-school assistance to at-risk children, including education, mentoring and other programs.

YES: $550 million for the President's Youth Employment and Skills crime prevention program, to provide jobs to young adults in high crime areas. Conditions program involvement on continued responsible behavior. Authorizes an additional $350 million from non-Trust Fund sources.

Violence Against Women Act: $1.8 billion to fight violence against women.

Includes funds to increase and train police, prosecutors, and judges; to encourage pro-arrest policies; for victim services and advocates; battered women's shelters; rape education and community prevention programs; a national family violence hotline, and increased security in public places.

Provides first-ever civil rights remedy for victims of felonies motivated by gender bias.

Extends "rape shield law" protections to civil cases and to all criminal cases to bar irrelevant inquiries into a victim's sexual history.

Requires all states to honor "stay-away orders" issued by courts in other states.

Requires confidentiality for the addressees of family violence shelters and abused persons.

Local Partnership Act: $1.8 billion for direct funding to localities around the country for anti-crime efforts, such as drug treatment, education, and jobs.

Model Intensive Grants: $895 million for model crime prevention programs targeted at high crime neighborhoods.

Community Economic Partnership: $300 million for lines of credit to community development corporations to stimulate business and employment opportunities for low-

Footnotes at end of article.

income, unemployed and underemployed individuals.

Drug Treatment: $425 million for drug treatment programs for state ($300) and federal ($125) prisoners. Creates a treatment schedule for all drug-addicted federal prisoners. Requires drug testing of federal prisoners on release.

Anti-gang grants: $125 million for programs to give young people positive alternatives to gangs (such as academic, athletic, artistic after-school activities, mentoring programs, scout troops, and sports leagues).

Sports Leagues: $40 million for midnight sports leagues to give at-risk youth nightly alternatives to the streets, and $50 million for the U.S. Olympic Committee to develop supervised sports and recreation programs in high-crime areas.

Boys and Girls Clubs: $30 million to establish clubs in low income housing communities, and $10 million to encourage police officers to live in those communities.

Triad: $6 million for partnerships between senior citizen groups and law enforcement to combat crimes against elderly Americans.

Police Partnerships: $20 million for partnerships between law enforcement and social service agencies to fight crimes against children, and for the creation of youth councils to combat crime.

Visitation centers: $30 million for supervised centers for divorced or separated parents to visit their children in "safe havens" where there is a history or risk of physical or sexual abuse.

DRUG COURTS—$1.3 BILLION

Provides $1.3 billion for drug court programs for at least 600,000 nonviolent offenders with substance abuse problems over the next six years. Participants will be intensively supervised, given drug treatment, and subjected to graduated sanctions—ultimately including prison terms—for failing random drug tests.[3]

FIREARMS

Assault Weapons: Bans the manufacture of 19 named military-style assault weapons, assault weapons with specific combat features, "copy-cat" models, and high-capacity ammunition magazines ("clips") of more than ten rounds.

Kids and Guns: Prohibits the sale or transfer of a gun to a juvenile, and possession of a gun by a juvenile.

Domestic Abusers: Prohibits gun sales to, and possession by, persons subject to family violence restraining orders.

Gun Licensing: Strengthens federal licensing standards for firearms dealers.

GANGS AND YOUTH VIOLENCE

Gang Crimes: Provides new, stiff penalties for violent and drug crimes committed by gangs.

Using kids to sell drugs: Triples penalties for using children to deal drugs near schools and playgrounds.

Recruiting, encouraging kids to commit crimes: Enhances penalties for all crimes using children, and for recruiting, encouraging children to commit a crime.

Drug free zones: Increases penalties for drug dealing in drug free zones—near playgrounds, schoolyards, video arcades, and youth centers.

Public housing: Increases penalties for drug dealing near public housing projects.

Adult prosecution of violent juveniles: Authorizes adult treatment of 13 year olds charged with the most violent of crimes (murder, attempted murder, aggravated assault, armed robbery, rape); authorizes grants to states for bindover programs for violent 16 and 17 year olds.

DEATH PENALTY

Expands the federal death penalty to cover about 60 offenses, including terorism, murder of a law enforcement officer, large-scale drug trafficking, drive-by-shootings, and carjackers who murder.

OTHER PENALTIES

Three Strikes: Mandates life imprisonment for criminals convicted of three violent felonies or drug offenses.

Miscellaneous: Increases or creates new penalties for over 70 criminal offenses, primarily covering violent crimes, drug trafficking and gun crimes, including:

Drive-by shootings; use of semi-automatic weapons; drug use, trafficking in prison; gun, explosives possession by convicts; sex offenses, assaults against children; crimes against the elderly; interstate gun trafficking; aggravated sexual abuse; gun smuggling; arson; hate crimes; and drunk driving.

TERRORISM

Death penalty: Creates new terrorism death penalty, and extends the statute of limitations for terrorism offenses.

Increased penalties: Increases penalties for any felony involving or promoting international terrorism.

Treaty implementation: Creates new offenses implementing treaties regarding crimes against maritime platforms and in international airports.

Informants: Creates new authority for the Attorney General and the State Department to bring witnesses to the United States to testify in terrorist crimes.

CRIMINAL ALIENS AND IMMIGRATION ENFORCEMENT—$1 BILLION

Deportation of criminal aliens: Provides a new summary deportation procedure to speed deportation of aliens who have been convicted of crimes.

Increased penalties: Increases penalties for smuggling aliens and for document fraud.

Funding: Provides a total of $1 billion for new border patrol agents, asylum reform, and other immigration enforcement activities.

CRIME VICTIMS

Right of allocution: Allows victims of violent and sex crimes to speak at the sentencing of their assailants.

Mandatory restitution: Requires sex offenders and child molesters to pay restitution to their victims.

Protection of Victims fund: Prohibits diversion of victims' funds to other federal programs.

FRAUD

Telemarketing fraud: Enhances penalties for telemarketing frauds targeted at senior citizens and multiple victims.

Computer fraud: Revises and expands computer crime offenses.

Insurance fraud: Creates a new federal offense of major fraud by insurance companies against their policyholders.

Credit card fraud: Revises and expands credit card fraud offenses.

FOOTNOTES

[1] Police Corps: Also authorizes $400 million from the general Treasury for college scholarships for students who agree to serve as police offers, and for scholarships for in-service officers.

[2] An additional $2.2 billion is authorized for prison and boot camps grants from the general Treasury (non-trust fund sources).

[3] The combination of prevention and drug court monies brings the total trust fund dollars for prevention and rehabilitation to $8.7 billion.

Mr. BIDEN. Let me just point out some of the recent criticisms that I have heard on television or on this floor from my Republican friends. One is that the crime conference report funds social welfare programs that have nothing to do with fighting crime. You have all heard that one, right. You heard that on the TV, read the paper lately. The crime prevention programs in the crime conference report are all, I might add, supported by law enforcement organizations. I ask unanimous consent that all the law enforcement organizations that have endorsed this legislation be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

SUPPORT FOR THE CRIME BILL

POLICE GROUPS

Fraternal Order of Police [FOP].

National Association of Police Organizations [NAPO].

International Brotherhood of Police Officers [IBPO].

National Sheriffs' Association [NSA].

International Association of Chiefs of Police [IACP].

National Organization of Black Law Enforcement Executives [NOBLE].

National Trooper's Coalition.

Major Cities Chiefs.

International Union of Police Associations [IUPA].

Police Foundation.

Police Executive Research Forum [PERF].

Federal Law Enforcement Officers Association [FLEOA].

PROSECUTOR GROUPS

National District Attorneys Association.

National Association of Attorneys General.

WHAT POLICE ARE SAYING

"* * * the FOP strongly believes that the crime bill will benefit the citizens of this nation and provide a strong safety mechanism for our officers doing the tough job on the streets * * * The Fraternal Order of Police believes that this Crime Bill has a balance of enforcement, prosecution/courts, prisons, and prevention, which will make a real difference in the incidence of crime over the next five years."—Fraternal Order of Police.

"* * * NAPO strongly supports the crime bill conference report * * * As law enforcement officers, it is our job to fight crime and now we are finally being given the help we so desperately need. We cannot win the war on crime unless we are given the additional resources contained in the conference report."—National Association of Police Organizations.

"The IBPO's strongly supports and endorses the Crime Bill Conference Report * * * The IBPO has long advocated comprehensive efforts to address violent crime where it occurs: at the state and local level. This crime bill represents historic achievements to accomplish this goal * * * The crime bill is an appropriate balance of police, punishment and prevention * * * critical to a long term cure * * * The Crime Bill Conference Report is the most comprehensive legislation Congress has ever proposed to combat violent crime * * * We urge you to take action now."—International Brotherhood of Police Officers.

"We need to do everything possible to stop the rising crime, especially in rural America where sheriffs have the vast majority of the responsibility. We support swift passage of the Conference Report * * * and hope that Congress will see to it that law enforcement

and our entire criminal justice system gets the help it so desperately needs."—National Sheriffs' Association.

"We strongly support the bills' provisions and desire to have it passed as expeditiously as possible."—International Association of Chiefs of Police.

"* * * we are convinced that the comprehensive legislation * * * Is a monumental milestone in assistance to local jurisdictions in reducing crime * * * we at NOBLE are fully supporting the passage of the crime bill. * * *"—National Organization of Black Law Enforcement Executives.

"* * * we believe that the compromise crime bill legislation just sent forward by the conference committee is necessary and we urge all members of the House and Senate to support it and the President to sign it."—National Troopers Coalition.

"We urge you to pass the crime bill * * * the legislation contains initiatives of great help to federal, state, and local police in their quest for safer streets."—Major Cities Chiefs.

"* * * the passage of this bill would be a landmark in balancing broad social interests while addressing the real day to day needs of street level law enforcement officers * * * with its immediate passage, the officers on the street will move forward knowing they now have the support they have needed for so long."—International Union of Police Associations.

"The failure of this bill to pass would represent a terrible blow to citizens who are besieged by crime and violence."—Police Foundation.

"PERF believes that this Crime bill is a balanced and reasonable response to the crime PERF members face in cities across the country. We urge every member of Congress to support police by voting for passage of the crime bill as outlined in the conference report."—Police Executive Research Forum.

"It [the Crime Bill Conference Report] is the most comprehensive piece of anti-crime legislation in the history of this country * * * FLEOA urges you and your colleagues for the quick passage of this very important piece of legislation. It is important to note that laws alone don't make people safe, law enforcement officers with adequate resources do!"—Federal Law Enforcement Officers Association.

PROSECUTOR GROUPS

"The National District Attorneys Association wholeheartedly supports the efforts of you [letter addressed to Senator Biden], and your colleagues, in structuring a Crime Bill that promises to make significant inroads in our national fight against crime * * * we believe that the final effort provides a balance of programs that hold the potential for making a vast difference for our nation in reducing the crime rate. We would urge that the Crime Bill be enacted."—National District Attorneys Association.

"* * * we are pleased to add our endorsement of your efforts and pledge the support of the Association in implementing the provisions of this bill."—National Association of Attorneys General.

Mr. BIDEN. I might add, every law enforcement and prosecutorial organization I am aware of, Mr. President, supports this legislation.

But let us talk about many of these programs they are calling prevention programs and pork.

The violence against women bill, $1.8 billion, for the first time making a concerted effort to deal with domestic violence and violence against women by strangers in this Nation. It is outrageous what is happening to American women, outrageous in terms of being the victims of violence. With bipartisan support, that Violence Against Women Act, although I wrote the bill, is supported by not only Senator BOXER on this side as a major cosponsor but also by Senators HATCH and DOLE on that side; the legislation was voted for by almost everybody in this Chamber, Democrat and Republican.

You know that Virginia Slims commercial, "You've come a long way, baby." That is the good news, "You've come a long way, baby." The bad news is, we have come a long way. More women now walk out of their offices at midnight, working for major law firms, newspapers, and corporations. They get raped in parking lots, and they get mugged at bus stops.

One of the things we found out—again not rocket science—is if you put intense lighting, just lights, shed light on places like that, crime drops. So we put millions of dollars in here for States to be able to put lighting in high crime areas where women are victimized. Big deal. It is a prevention program. I challenge my Republican friends to stand up and introduce an amendment to take it out.

Another one, community schools: $900 million; $125 million, antigang grants, a Hatch amendment and a Dole amendment; $425 million for drug treatment in prisons endorsed by William Bennett, former drug czar, now keeper of the principles of all Americans. The list goes on.

By the way, midnight basketball, my friends like to talk about midnight basketball. Do you know where we got the idea? It was one of those "thousand points of light" that President Bush shone upon all of us. It was a Bush idea. And it shone with such brightness that it was hard to resist. Guess what else? It is not midnight basketball to just go play basketball.

How many of you in the Chamber have helped the communities to try to raise money for Boys Clubs, Girls Clubs, the YMCA to try to take kids off the streets? Why do we close down schools at 5 o'clock in the afternoon? Why do we need to build new gymnasiums? Tell me. Why? The reason why is we close down the schools.

So communities have had some pretty good ideas. They found that when they keep the schools open, bring in social workers and keep the school open until midnight, and take kids off the street. Guess what? You do not have to build a new building. Guess what? Crime rates drop among juveniles. Big deal. Is not that a touchy feeling social program?

I hear my colleagues talking about the return of the Johnsonian era. What are they talking about? Which Johnson? This century or last? What are they talking about?

By the way, guess what, Mr. President? These kids, in order to get into many midnight basketball programs, have to be in school. They have to have their grades up. Guess what? They do it. Guess what? In cities with midnight basketball, those kids are in the gyms instead of out on the streets doing drugs and committing crimes. So $40 million for midnight basketball was a good, solid Republican idea. Now it is a bad idea.

By the way, there are people in this room, people listening to this, who want to know how we hang them. We have a whole list of "hang him high." We have $21 billion of "hang him high" stuff in here; $21 billion dollars for cops, law enforcement, and prisons.

Let us talk about a few other facts versus fiction. This is a good one. By the way, I was handed a little card that was like a monopoly card where you play monopoly. It says "Get out of jail free," and they have a fat little guy in tails who looks like he is fleeing the jail. I have to give my Republican friends credit. They are very good. I have been here only 22 years. I marvel at how much better they are than we are. One of them handed me a little yellow card. I wish I had it in my wallet. I gave it to the conductor on the train on the way down. It is a little yellow card with a guy getting out of jail free.

It has release—what is it, 10,000?—10,000 drug felons. That is what this crime bill will do. Oh, man. When I heard that, I thought how could I be for that? I wrote it. How can I be for that? I am letting out 10,000 of those people. Then you look at what is in the bill. I went back and read it. Maybe I missed something here.

Let us talk about what it is. Let us talk about who sponsored it. HENRY HYDE, that liberal Republican from the House side, and Mr. MCCOLLUM of Florida, that other liberal Republican from the House side, along with Democrats as well, came up with a thing called a safety valve. Over here in the Senate, Senators THURMOND and SIMPSON also came up with a safety valve with Senators KENNEDY, LEAHY, and SIMON.

That is what we are referring to hear about this 10,000 people who get out of jail. The safety valve passed in the House says that, if you have been sentenced to jail on a flat sentence, a minimum mandatory sentence, or a drug offense, that you have an opportunity to petition to determine whether or not you could have that flat sentence looked at, reduced, even though it was a flat sentence. I was not for it. Some of my Republican friends were for it, not all; the lead Republicans, on the conference in the House; some of my Republican friends and some Democrats. Let us talk about what it does.

No one gets out of jail under this narrow so-called safety valve which applies only to nonviolent drug offenders; it permits them to ask to be sentenced under the sentencing guidelines, not be set free. Most offenders will not have to be resentenced because the new sentence they receive under the sentencing guidelines would be longer than the sentence for which they were sent. The Bureau of Prisons estimates that if this were law, 100 to a maximum of 400 nonviolent drug offenders would be eligible for release under this provision. That is the truth of the matter and what this bill says.

But, yet, when I heard on television my friend saying—I will not mention his name—"I cannot be for this bill. There are going to be released 10,000 violent drug offenders," I thought, Oh, my God. Maybe AL D'AMATO was right. We slip things into these bills that we do not know. It is simply not true.

Another one that is sort of the currency now—a few more of these, and then I will sit down. I will be doing a lot more of this over the next week or so. It will not be as informative as the Presiding Officer's speeches on the history of the Senate. But it will have the same intent—to educate.

The crime bill, we are told by my Republican friends, does not allow communities to be notified when a sex offender is released from prison. I heard that, too. I turned to Cynthia Hogan, chief of staff, and a very bright lawyer, and I said, "Cynthia, did we have this in my bill? Did that not happen to get in the bill? What happened here?" They said it just factually, that it was not in there. She said, "No. It is in the bill. It is in the conference report."

Let me tell you what is in the conference report. It requires the State to create registries of sex offenders; requires law enforcement to keep track of those offenders' whereabouts after the release from prison; and the provision explicitly permits law enforcement to give notice to the community to serve law enforcement purposes and to give the police immunity from releasing that information.

When my friends found out it was not in the bill—maybe those criticizing were not sure it was, in fairness to them—and we pointed out it was in the bill, they said, "Oh, we want it changed." I said, "What change do you want?" They said, "We want to make it mandatory"—we make it mandatory that there be a registry, that the police be informed; when the sex offender, after having served time, moves from one community to another, the scarlet letter follows them, and the next community is informed; we make all that mandatory. I said, "What do you want mandatory?" They want it mandatory that the police notify the community. I said, "They can do that now." They said, "No, we want it explicit, something in law saying they must." I said, "What do you want to do, take out television ads, hand out fliers?" What is the indicia you are going to put in there to demonstrate that they did not? I said, "Do you have language? I will take it." And they still go around saying that sexual predators, having served their time, are not required to be part of a registry, and now and forever, every community where they move will be notified.

By the way, it sounds pretty draconian from a civil libertarians viewpoint, Mr. President, and the reason is that the only place where the evidence seems to indicate that we are totally incapable of rehabilitating is in the area of sex offenders, repeat sex offenders. So the fact that they have served a prison sentence, I am told—and I do not consider myself an expert here—I think I know a fair amount about the criminal justice system, but I do not pretend to have all the information on this point. But I am told by the experts that these people are the toughest to rehabilitate. So it makes sense to notify communities that sexual offenders, having served their time, are in the community.

My Republican friends keep running around saying—by the way, a tragic thing happened in our neighboring State of New Jersey. A young girl was murdered, allegedly by a released sex offender who moved into the community across the street, a neighbor, and the family or the neighborhood never knew that a sex offender was living in that house. It created an uproar, as it should. But we already took care of it in this bill that the Republicans are preventing us from being able to pass. They keep saying, "It is not in there." It is.

Another fact—and we will go through three more and I will yield the floor and come back another time. The two other things we most often hear is the crime conference report will fund only 22,000 police officers, not 100,000 new cops. That is the refrain I hear. Where they come up with 22,000, I do not know. Let me tell you what the facts are. The crime bill does provide for 100,000 new cops. It provides $8.8 billion in a trust fund for that. It provides $7.5 billion—$75,000 per cop over a 6-year period totaling 100,000 cops; the $1.3 billion that is remaining is for implementing and administering community policing, which is new to most communities and costs money. They need help doing it.

The program requires that the State match this commitment in Federal dollars over a 6-year period. But under the fiscal year 1994 budget, $150 million in police supplemental money, having exactly the same matching requirements for cities and States, and your cities and your States, I say to the Presiding Officer—Delaware, California, Florida, Texas—fell all over themselves to try to participate in this $150 million program, which the distinguished chairman of the Appropriations Committee funded for the fiscal year 1994 budget. And we are funding $8.8 billion over the next 6 years. What is different? Mayors and local officials today strongly support this program because they know it is real help for putting cops on the street.

The last point I will mention for the time being is that we are beginning to hear a slow rumble that I am counting on—and I say this seriously—when the debate takes place, that the debate will be led by the President pro tempore on this point, which is that we are hearing now, as if it is a new notion, that a point of order will lie to the conference report when it comes over here, as if we did something in the conference that generated a "point of order."

Well, as people on this floor know, the violent crime reduction trust fund is, and always has been, subject to a budget point of order objection, because it is within the jurisdiction of the Budget Committee, but did not go through the Budget Committee before being offered on the floor of the U.S. Senate.

Let me be crystal clear. When the trust fund was offered as an amendment on the floor of the Senate last November, sponsored by Senators BYRD, MITCHELL, HATCH, GRAMM, DOLE, DOMENICI, BIDEN, and others, this same point of order was in order then, as it is now. And the reason it was in order then, as it is now, is that this trust fund notion did not go through the Budget Committee. Indeed, since that time, my Republican friends—at that time, my Republican friends ardently insisted time and time again, as we moved toward conference, and they even passed a resolution instructing the chairman of the Judiciary Committee, yours truly, to insist in the conference that we keep the trust fund. Is that not strange? They said: BIDEN, we do not want you jimmying around over there, doing what those House guys do. The House guys did not have a trust fund. They did not have this in a trust fund. This was not real money. We insisted on it.

So the Senate and my Republican colleagues insisted that I go to conference and keep the trust fund. I was all for keeping the trust fund. Like I said, it was not my idea. I wish I could have claimed credit for having thought of it. This is the best thing we have done on crime, in my view. So I kept it in the conference. The House yielded to the Senate. Now I am being told by my Republican friends that they are going to insist on a point of order. Translated for the listeners, that means 60 votes are required before we can move forward.

Well, that is good politics, but it is not totally consistent with what Barry Goldwater used to say when he served here: "In your heart, you know I am

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right." Remember that phrase? In their hearts, they know they are wrong. In their hearts they know. They asked me to keep the trust fund in, and in their hearts they know the trust fund is a good idea, and in their political soul, they are going to ask for a point of order requiring me to get 60 votes. Funny thing, we do not have 60 Democrats. So it is going to be hard.

But let us be honest. Why are we hearing about the point of order now? This is pure partisan politics, pure game playing by those who would rather see and score political points than give the American people help in fighting crime.

Mr. President, I thank my colleagues, who are here to discuss health care, for their indulgence. But there is no other time in the midst of this public debate that is going on to set the record straight. I stand ready to debate any one of my colleagues, not because I am any smarter, better, or any less or more informed, but because I know what I said here to be correct. I stand ready to debate them on any of the points raised here, and I challenge them to suggest to me why what I said here is not true. It is possible that I could have made a mistake, but I have spent 6 years on this.

The criticisms being made to the bill by my Republican friends are simply not real. The real criticisms of the bill that are occasionally made are that this bans assault weapons, military style assault weapons, less than 20 in number. There are Senators like my friends from Idaho, two Senators from Idaho, who feel very strongly that it is unconstitutional to do that.

I respect their point of view. I respect that. I disagree with it.

I teach the second amendment in law school in the course I teach. I believe the second amendment is real. You cannot ban all weapons. We are not trying to do all that. If you acknowledge that you can ban any weapon, then you already acknowledge it is not absolute.

For example, I wonder how many people think someone with enough money can buy an F-15 loaded with ordnance, or someone should be able to buy a theater nuclear weapon, or someone should be able to buy a hydrogen bomb? Obviously, it is crazy. People should not be able to buy those things. The second amendment says they have a right to bear arms. They are arms.

If you say you cannot ban those, why is it so outrageous to say something that has no utility other than to kill a person should be able to be banned? But there are some who believe it is unconstitutional. I respect them for that.

So, that is a legitimate argument against this bill. But you should have the courage to stand up and tell the American people: I am against this bill because I do not want to ban assault weapons, even though I know it means 100,000 cops down the drain, 105,000 prison cells down the drain, 600,000 people now walking the street won't go into intense supervision. I think all that should go down the drain; 30,000 violent offenders in the States last year who were convicted but never served a day behind bars because there are no prison cells. They should continue to walk the street because the principle on the second amendment is important to me.

I respect you for that if that is your view. Say it. Do not say this releases 10,000 drug offenders. Do not say this is $30 billion in new taxes. Do not say that this is pork. Do not say that there are not 100,000 cops.

By the way, I have less respect for—but I have been around long enough to have a serious appreciation for—a party that says, hey, look, our way back is to make sure we decimate this fellow in the White House. I understand that. I am a big boy. I have been around awhile. I am getting to be an old guy. I am 51 now. I have been here since I was 29. It took a while to learn. I learned. It is called hardball politics. A lot of people play hardball politics, Democrats and Republicans. I do not suggest they do not have a right to play hardball politics.

How many times have you heard the Republicans say and Democratic friends echo if the President loses the crime bill health care is in trouble? If the President loses the crime bill, he is in deep trouble.

That is stating the obvious. He is. If you want this crime bill to go down, because it is going to bring the President down, thereby enhancing the chances a Republican President will be elected, thereby from your standpoint the country will be in better hands and, therefore, what you are doing is for the good of the country, that is OK. I understand that argument. But make it straight up. Make it. Make it. Do not do what the Republican national chairman did so it was reported in the press—contact Republicans in the House and say that if you vote for this, you are going to be in real trouble—I am paraphrasing—you are not a loyal party person.

Now they say that was not done. Why was there a requirement on the part of the House leadership to hold up a letter coming from the Republican national chairman saying, "By the way, you can vote for this bill if you want"? Is that not an unusual thing? Who was it? I would yield to the Presiding Officer except he cannot respond. He would know. Which one of Shakespeare's characters said "He doth protest too much?" I think the national committee chairman doth protest too much when he has to write a letter shown on the floor of the House saying: "It is OK. You can vote for this Democratic crime bill and we will not do anything to you."

He doth protest too much. I am not even sure I got the quote right. But I got the principle right. I got the facts right. And I got my Republican colleagues right in the political crosshairs. I understand that.

Say it. Sing it. Be proud of your party discipline. But do not tell me you are letting out 10,000 drug felons to maraud the community. Do not tell me we are raising $30 billion in new taxes.

This bill went down in the House last time because of the RNC and the NRA. Forty-eight Democrats voted against the bill because of guns. I respect their view. I think they are dead wrong. I respect their view.

Anyway, I think it is time for a little bit of truth in legislating. We want to debate the facts of this legislation. I stand ready to do that. Hopefully, I will be up for the task. I know my blood is up for that task. I know I have never been as frustrated, I must say with anything in my whole life. This is a bill that every police agency that I am aware of, Republican and Democratic alike, is for this bill. It is the toughest crime bill we ever drafted. It has serious, serious efforts in there to deal with violent offenders, and it has a serious and rational effort to deal with prevention programs that work.

A FEW EXAMPLES OF CRIME PREVENTION PROGRAMS AT WORK

Boys and Girls Clubs:

A 1992 evaluation by Columbia University and the American Health Foundation found that public housing projects with clubs experienced 13 percent fewer juvenile crimes; 22 percent less drug activity, and 25 percent less crack presence than projects without clubs.

Communities in Schools, Houston, TX—this program aims to keep at-risk kids in school—as opposed to out on the streets committing crimes. Professionals set up shop in the schools and provide one-on-one counseling, mentoring, tutoring, job training and crisis intervention.

An independent evaluation reported that approximately 90 percent of the kids served by the program are still in school at the end of the school year. In contrast, one-third of students entering high school statewide fail to graduate.

Police athletic teams [PAT], Birmingham, AL—the Birmingham Police Department sponsors softball, basketball, baseball and golf teams for kids from disadvantaged neighborhoods. The catch: The kids must study for at least an hour every night (the program supplies tutors) and must maintain a C average in order to play.

The Police Department reports that juvenile crime has dropped 30 percent in neighborhoods served by the program.

Southwest Key Day Treatment Program, Austin, TX—southwest Key caseworkers provide round-the-clock tracking of kids who have had a brush with

the law, and who are out on probation or parole. The program counsels the kids and their parents, and also requires the kids to attend daily work-related, social skills and recreation sessions.

The Texas Youth Commission reports that the kids who complete the program have a 65 percent lower re-arrest rate than kids released from institutions directly into standard parole services.

Project First Class Male, Fort Lauderdale, FL—in this program, counselors meet with at-risk young boys at school and in their homes with an eye toward promoting sexual abstinence and reducing teen pregnancies.

An independent evaluation reports an 85 percent success rate in preventing new pregnancies.

The Phoenix House, New York, NY—Phoenix House provides live-in high schools for juvenile drug abusers. In addition to traditional curricula, the program helps kids kick their habits and develop self-esteem, discipline, and personal responsibility.

Phoenix House reports that 85 percent of its graduates remain drug and crime free for the 3 to 5 years that the program charts their progress.

The Juvenile Diversion Program, Pueblo, CO—this program for nonviolent first time offenders requires kids to sign a behavioral contract and become involved with a nonprofit agency; the kids are also tutored, counseled, and required to pay restitution to their victims.

The program reports that 83 percent of its graduates are not re-arrested in the 2 years the program follows them.

"STARS"—Success Through Academic and Recreational Support, Fort Myers, FL—STARS, which has received accolades from Republican Senator CONNIE MACK, provides at-risk kids with positive, adult-guided tutorial and recreational programs.

The Fort Myers chief of police reports that, in the last 3 years, the program has led to a 27 percent reduction in juvenile arrests and a dramatic reduction in repeat-offender arrests.

Specialized Treatment Services, Mercer, PA—this program targets delinquent kids with mental health problems for intensive counseling and academic services.

The program reports that more than 80 percent of the kids who complete the program do not get into serious trouble during the 5 years that they are tracked upon release.

Mr. President, I used to have a schoolteacher and a grandmother who used to use the following phrase when she looked at me. I remember back when I was a kid in the fifties Boys Town was a big deal. You know, "He ain't heavy, Father. He's my brother."

Coming from a large Catholic family that was a big deal thought. It was one of the things my grandfather Finnigan talked about, so on and so forth. I am proud of that. That is not belittling. I was very proud.

I never forget, in addition, one of the other phrases that Father Flannigan has. "There is no such thing as a bad boy." I am not so sure he is right about that. But I am prepared to accept that.

One of the things my grandmother said seems to be proven true by all the studies we have done and all the hearings we had. She used the phrase that is used probably in 50 different ways by 50 different cultures and a million different people. She always used to say: "Joey, an idle mind is the Devil's workshop." An idle mind is the Devil's workshop. Sounds kind of corny, does it not, Mr. President?

Like I said this is not rocket science. These are kids who are about to enter the drug stream and the crime stream, and one of the few things that stands between them and entering those drug and crime streams is an opportunity to be diverted—not converted—diverted from the idle mind that lets them sit in the projects up against the school brick walls on those hot summer days and decide whether or not to take that crack vial and try it or go into a basketball gymnasium or go into a system where they have people from the community, Big Brothers and Big Sisters, who are tutoring kids. That makes a difference.

Nothing in here is new under the Sun. And $3.7 billion dollars of the prevention programs my Republican friends now call pork they supported on this floor, and many of them are Republican initiatives, like Senator DOLE's initiative.

I am going to read Senator DOLE's quote from his legislation. He is the one talking about all this pork. It is one sentence, if I can find it quickly here. It is a $100 million juvenile drug trafficking and gang prevention program which I had in the bill, which he amended and wanted to make his legislation, which we did. Let me tell you what it says. It says:

This is Senator DOLE-sponsored legislation that was originally the bill that he amended. He said, $100 million to

* * * develop and provide parenting classes for parents of at-risk youth.

Not a bad idea; pretty good idea.

* * * to develop and provide training in methods of nonviolent dispute resolution to junior high school and high school age children.

* * * to establish sports mentoring and coaching programs in which athletes serve as role models to juveniles. To teach that athletics provides a positive alternative to drug and gang involvement

That is ROBERT DOLE, the man who stands here and belittles midnight basketball, and what does he call it? Tap dancing in prison. Where that came from, I do not know.

If for midnight basketball you were required to be in school, where you are required to maintain a C average, where you are required to be in a study hall, et cetera, if that is some flaky program, what is this thing? What is this thing that he voted for, put his name on, that all those folks over there voted for?

It went from here to there—they are wonderful alchemists, I would say to my friend from West Virginia. It went from a substantive program—as it made its way up that aisle, it got halfway down that corridor on the way over to the House of Representatives and it got midway and fell into a conference and it became pork. How did that happen?

I think it got politically barbecued as it made its way out this door. So I will not use the phrase, "what is one man's pork is another man's politics"—paraphrasing, "What is one man's meat is another man's poison." But it seems to me that there is a little alchemy 20th-century style going on here.

It is politics. So far it is very successful politics. So far obstructionist politics works better than constructionist politics. But it is politics. Just so the American people know what it is, that is all I care. If they conclude that team is right, that is what they want to do—well, that is what democracy is about. I will be back here next year. I am here for at least another 2 years, God willing and the creek not rising and my health maintained. I will come back at it again. But it is outrageous to suggest that this bill should go down for some of the reasons that are suggested by my Republican friends.

I thank my friend from West Virginia for his indulgence, allowing me to enter in the middle of this health care debate. But it seems to me, the same kind of shenanigans are going on on the health care debate that are going on on this crime debate, and, as I said, a little truth in legislating and debating might be useful.

Several Senators addressed the Chair.

The PRESIDENT pro tempore. The Senator from West Virginia.

HEALTH SECURITY ACT

The Senate continued with the consideration of the bill.

Mr. ROCKEFELLER. Mr. President, I want to compliment the Senator from Delaware on his remarks and say I agree wholeheartedly with not only what he said but with the thrust of what he said.

It is very obvious now that Senators who want to pass a health reform bill are going to have to spend many long days and nights in their effort to do so. This is not happy news for our families—our own families. I shudder to think of some of the conversations—I know the one that took place in my own house last night—many of us with

spouses and children have had about canceling plans. Many who are not so fortunate financially have had to lay down nonrefundable tickets to places and they cannot get their money back. They want to go camping or visit relatives.

Nevertheless, we are here to do the work that the people want us to do. So we shall stay until this health care reform bill is passed, 24 hours a day if that is the right amount of time. And I am delighted, personally, that we are doing it. I think it is the kind of leadership and toughness which is correct.

But then we also have to remember why so many of us are unwilling to give in to the faction that is arguing for delay, or for postponement, for doing nothing, for ignoring the problems, for accepting things exactly the way they work and accepting them for the way they do not work.

Mr. President, I have a stopwatch here, and I arrived on the Senate floor about 90 minutes ago and have been waiting to speak since that time. I have made a simple calculation that during that time, the 90 minutes I have been waiting to speak, that 4,698 Americans have lost their health insurance and that 1,368 American children have lost their health insurance.

Yes, the voices for delay and obstructionism are right when they say that in that same time, other Americans, other children got back their health insurance. That is true. It proves the point about one distinctive feature of America's so-called health care system and that is that it is the ultimate revolving door. Yes, we are a country where health insurance can be returned. But for the most part we all know when we talk about 39 million Americans being uninsured, we are really talking about 60 to 64 million Americans who, for some significant part of a year, do not have health insurance.

Yes, we are a country of researchers, doctors, nurses, hospitals, vast medical complexes, drugs, medical discovery and breakthroughs. And that we all celebrate.

But we are also a country that leaves basic health security for its people, for its children, to something called "pure chance." If you work in Germany or France or Japan, you can count on basic health security in the same way that you can count on the Sun coming up. It does not fail. If you work in the United States of America, you cannot count on health insurance, whether you have it or whether you do not—unless you are lucky enough, that is, to live in Hawaii.

In America, playing by the rules, working full time, paying your taxes, does not mean that you can stop worrying even for one second about whether you can take a child to the doctor for a checkup or get some tests when a serious ache or pain sets in—unless, that is, you are lucky enough to live in Hawaii where they are approaching universal health insurance coverage.

If you have health insurance in the United States of America but have to change jobs, that is when you better start worrying. You better make sure you do not have something called a preexisting condition on your records, because in America that means that any insurance company can slam the door in your face—and they do. I said last night—I see the Senator from Connecticut here—that it is absolutely beyond my wildest imagination that in this country called America, a young woman who is married and becomes pregnant but who does not have health insurance—becomes pregnant and then goes to try to get health insurance, cannot get health insurance because she has something called a preexisting condition; to wit, she has become pregnant. Only in America. That is why so many of us feel we have absolutely no choice but to go on and on and to persist and to persist.

Here we are trying to advance a bill—it happens to be the majority leader's bill—that does exactly what the vast majority of Americans have said over and over and over again that they want from this Senate and from this Congress and from this town. They want their health insurance to be there when they need it. They want their health insurance to be there when their children need it. They want their health insurance to live up to its word, to its printed word, and not hide dirty secrets like lifetime limits, exclusions for past illnesses, in a sea of fine print. And how many times have we seen that in our various States?

Americans want the revolving insurance door to stop. They want to focus on raising their kids, saving up for college, doing a good job at work instead of worrying that one false move, one accident at school or at the school playground—one lump will pull the rug out from underneath them.

I repeat, since arriving here this afternoon in the Chamber, more than 4,698 Americans have lost their health insurance and more than 1,368 children have lost their health insurance. That is in the 90 minutes that I have been waiting to speak. The revolving door turned them out. A few of them may get back in, but the revolving door has now turned them out, so even if they get back in, they could go out again, and they know it.

Now to turn to the very specific question before us. I also want to say something about the amendment from the good Senator from Connecticut, Senator CHRISTOPHER DODD. Talk about an idea that is as clear as day. This amendment calls on insurance plans to remember children when figuring out what it will cover and what it will not cover.

As my distinguished senior colleague knows, I was proud to Chair the Bipartisan National Commission on Children just a few years ago, and it gave me the opportunity to travel across this country, across our State of West Virginia and meet with thousands and thousands of parents and children in all different kinds of situations, in the worst housing development slums in Chicago, to barrios in San Antonio, to all kinds of places.

Those of us who served on the Commission were incredibly diverse—diverse in our background, diverse in ideas, diverse in our philosophies, diverse in our professional backgrounds. There were, in fact, three members of the Bush administration, acting officials of the Bush administration, on that Commission.

But after 3 years of studying life of families and children in America, we reached the same unanimous conclusion. Fortunately, no one tried to keep us from concluding our work through filibusters. Our conclusion was that America has to turn what we say about children into deeds in terms of what we do about children and families.

The amendment before us, the Dodd amendment, tries to do precisely that. One of the essential ways to help families is to make sure that their insurance covers the most basic kind of health care for their children. It is a simple proposition. If you have private health insurance, it should cover what counts the most. If you are a family with children, the amendment says that your insurer has to cover the basics—prenatal care for pregnant women, essential care for babies, immunizations, and the like.

If we care about children and families, as we all say we do, we must come together on health care reform. How can we pretend that basic care for children should be left to chance—that is what we do today—left to economic chance, left to circumstantial chance? Even the insurance companies are not fighting CHRISTOPHER DODD's amendment.

Five million women in America have private insurance policies this day that do not cover maternity care—5 million. That might just be a reason that so many pregnant women do not get the prenatal care that they should be getting. Not the only reason, but certainly a very big one.

One out of every 10 under the age of 10 in America, I am embarrassed to say, is uninsured. Talk about costs. These are children whose earaches can turn into lifelong disabilities, probably will turn into lifelong disabilities, who develop diseases that can be prevented with medicines and vaccines, all things which are readily available to us as an advanced industrial society, and who head for school, therefore, without the benefit of all of these things are already behind. We talk about Head Start, these children are starting way behind.

We have to do something about this, Mr. President. We have to weigh and measure and contrast the Mitchell plan, or any other plan, with the costs and the consequences of doing nothing. The numbers of uninsured children can be absolutely numbing, if you try to see them in your eye. I think of certain ones in West Virginia, Minnesota, and other places that I have been, but when you think in terms of the numbers of millions of children, it just becomes numbing, and then you know that in no other industrial society are any children uninsured, except in our own.

So let me share one story of a West Virginia family, that I visited recently, with the Presiding Officer and my colleagues who might be listening, the Bosworth family in Wheeling, WV.

The Bosworths are good people who are struggling. They have two daughters, Stephanie, who is 23 years old and who has cerebral palsy, and Nicole, who is 15. Steve, the father, was a salesman but became unemployed and is working odd jobs whenever he can find them. His wife, JoAnn, works part time at their church. No insurance involved in either case.

The family, in fact, tried to buy insurance, but because Stephanie has cerebral palsy, the cheapest plan that they could find to buy was $400 a month; hence, $5,000 a year, way out of reach for the Bosworth family, just out of the question. They could not afford it and, therefore, could not get it.

Medicaid covers Stephanie's health care, but the rest of the family is uninsured. Steve and JoAnn—the father and mother—and Nicole simply cannot get the health care that they need because they have no health insurance. Remember, they are both working as best they can. Nicole, the younger child who is 15, recently had a seizure and the family has no idea what the cause was. Without insurance, this young teenager has the seizure and does without medical analysis.

Our system is unfair, Mr. President, for Nicole Bosworth. Our system is unfair for the Bosworth family. The father is working and the mother is working as best they can, but they cannot scrape together enough money to buy health insurance.

They are fortunate that the child with cerebral palsy has Medicaid, but they are unfortunate in every other aspect of their life, as far as health care is concerned.

Under the Mitchell bill, over 7 million children will get insurance. Under the Dodd amendment, coverage for preventive services, children and pregnant women would begin in July of next year, less than a year from today. In West Virginia, the Mitchell bill would give 74 percent of children who are uninsured today coverage by 1997 and coverage for the rest would be phased in over the next few years.

Forty-eight thousand children will get private health insurance coverage—not Medicaid—but private health insurance coverage through this bill. At the end of our debate, I want to be able to go back to Wheeling, WV, and I want to tell the Bosworth family that they can sleep this night, or maybe tomorrow night knowing that their Nicole will have something called reliable, affordable health insurance coverage. I think that is a dream that ought to come true, and it just so happens that that is a dream that we can make come true if we adopt the Dodd amendment.

Mr. President, I thank the Presiding Officer, and I yield the floor.

Mr. McCONNELL. Mr. President, having been here a couple of hours and having listened to debate on other subjects than health care, I am here principally to talk about health care reform but I did want to make one observation before beginning.

I listened with considerable interest to my friend, the junior Senator from Minnesota, earlier this afternoon railing about the contributions from political action committees and asserting that somehow that was slowing the process of health care reform. I am not here to make a campaign finance speech, but I want to make a couple of observations.

No. 1, political action committees—of which Republicans are no fan, I might add. And, as a matter of fact, I was the first Senator to suggest that we get rid of PAC's altogether, a proposal which was subsequently adopted as the Senate position in the campaign finance bill last summer. But it is interesting to note that the PAC's, which my friend from Minnesota believes are slowing down the process, in the last cycle in Senate races gave 57 percent of their money to Democrats and only 43 percent to Republicans, and in the House 67 percent to Democrats and only 33 percent to Republicans. In the House of Representatives, the political action committees gave 67 percent of their money to Democrats, only 33 percent to Republicans.

My own view is that the PAC's are not buying influence on this issue. I think this is an issue much too important to the American people to be sort of kissed off in terms of political contributions. If anything buys votes in the health care debate, it is promising big taxpayer-funded solutions to these problems. There are those on the floor of the Senate who would seek to buy those votes with tax dollars by promising this group or that group or this group that the Treasury is going to pick up the tab for your problems. If anybody could rightly be accused of trying to buy votes on health care reform with dollars, it would seem to me it would be those who use, not their money, not the money of the political action committees, but the money out of the Treasury, out of the Treasury I repeat, to promise benefits to one group after another.

Of course, those are largely the same people who would like to dip into the Treasury to pay for political campaigns as well—the ultimate perk, the ultimate entitlement. There are those who seriously believe that we ought to start a new taxpayer entitlement program for each of us as we sit here on a multitrillion dollar debt.

That is a subject for another day, and I raise it only by way of observation after listening to my friend, the junior Senator from Minnesota, whose position I believe is that we should have a single-payer system. That is the ultimate, total, final Government takeover of health care, the ultimate buying of influence, if you will.

With regard to the subject before us today, I want to start by reiterating a point the Republican leader made very effectively in his opening statement just the other day. It bears remembering as we move down the road toward some kind of health care reform.

America has the best health care system in the world. America today has the best health care system in the world. Right now, every other nation on Earth looks to the United States as the quality leader in health care, the leader in surgical innovation, the leader in pharmaceutical breakthroughs, the leader in medical technology, the leader in health care education, the leader in hospital design, and the leader in health care management.

Now, Mr. President, the second point I wish to make is equally important. The reason why America has the best health care in the world is not because of some mammoth legislation enacted by Congress. It is not because of any regulation implemented by the U.S. Department of Health and Human Services, and it is not because of some health care task force put together by the White House. It is because the free market system and the forces of competition gave an incentive to hundreds of thousands of individuals and companies to improve the quality and availability of health care services for every single American.

The Government did not make our health care system the best in the world. People did, people who are highly trained, totally dedicated, and thoroughly experienced—and free to make a fair and honest wage from the work they do so well.

Yet, we have before us today a massive, 1,400-page social experiment based on the dubious premise that the Government can do a better job of managing our health care system than the hundreds of thousands of dedicated experts who do it every day, 52 weeks a year.

Somehow, the Government that purchases $200 toilet seats and $60 nails is going to bring cost efficiency to hospitals and doctors' offices.

Somehow, the Government that leaves millions of postal letters languishing in warehouses in the District

of Columbia is going to make millions of delicate decisions about who gets what kind of health care services and when they get them.

Somehow, this same Government that absorbs more and more of our paychecks every year is going to give us a bargain, a bargain on our health care.

The President and his allies in Congress would have us believe that if we just turn our health care system over to the Government, we will get a Neiman-Marcus product, with Tiffany's accessories and Nordstrom's service, all at K-Mart prices. What is not to like about that? But when you test this dubious premise against the daily practical experience of most taxpayers, it just does not hold any water.

Because of that, the American people have become deeply fearful of what Congress may be about to do to the best health care system in the world, deeply fearful about what we may do to the best health care system in the world. By an overwhelming margin, Americans are telling us that Congress should not pass a radical, top-to-bottom restructuring of our health care system. According to a USA Today-CNN survey conducted just a few days ago, voters favor a gradual, multiyear approach to health care reform instead of the radical Democratic leadership bills, by a margin of 68 to 28 percent.

I heard the Senator from New York, Senator D'AMATO, talking about the phone calls he had gotten in his office, various offices in New York over the last few days. Just looking at the mail count in my office just since last Saturday—looking at only the mail now, not the telephone calls; I have received 68 pro Clinton-type reform letters; 1,011 against. And again looking at letters since the last week of July, 250 letters in favor of the Clinton approach; 4,251, against.

Now, looking back at the USA Today poll, which assesses the mood across the country, nearly 60 percent of our constituents believe that the middle class, as usual, will be hurt the most by the steep tax increases and the social engineering contained in both the House and the Senate Democratic bills. And even more than the important issue of universal coverage, voters are concerned that Congress will pass a bill that gives the Government too much control over their health care.

Are the voters just misinformed, as the White House spin doctors claim? Folks out there, I guess, are not smart enough to know what is going on. That seems to be the White House position. Perhaps they are simply unable to comprehend the great public policy issues which the administration has so thoughtfully resolved for them. Just a communications problem, the White House says. People do not understand what is going on. And apparently they have been preaching to members of their party to rise above those nasty people. The way to be a profile in courage is to go against your constituents.

It is an interesting argument, Mr. President. The American people, I do not think, see it that way. They do not think they are misinformed. They do not think they do not know what is going on. They would like for us to respond to their desires on this issue. In fact, the American people are a lot smarter than the Democratic leadership gives them credit for. I think they have figured out the Clinton bill and its Democratic offspring.

They figured out that it was putting the Government in charge of their personal health care. They figured out that the Democratic leadership bills would set spending caps through global budgets that would eventually result in health care rationing. They figured out that these bills would herd them into Government purchasing monopolies, and force one-size-fits-all policies on everybody, whether they like it or not.

Our elderly constituents have figured out that these bills would cut deeply into Medicare spending. They have figured out that a Government-run health care system would be more expensive, more bureaucratic, and less responsive to each individual's medical needs than the system we have today. And the American people clearly do not want any part of it. I mean virtually every phone call coming to my office here and into the six offices in Kentucky are about this. They do not want it. Nobody can orchestrate this kind of telephone contact. I have never experienced it before in my 10 years in the Senate.

Could it be that the majority leadership is right, and millions of Americans are all wrong? Let us take a look at the bill before us to attempt to answer that question.

First of all, this bill would radically change our entire health care system from top to bottom, radically change it. It would change the way Americans obtain insurance, what kind of benefits they would be allowed, and how much they would have to pay in premiums, not to mention new taxes and how much the Government would be involved in deciding all of that.

The bill before us contains 8 new entitlements, 17 new taxes, 50 newly minted bureaucracies, 177 new State mandates, and nearly 1,000 new Federal powers and responsibilities. The Great Society is over. Welcome to the "Great Bureaucracy."

If this bill becomes law, the competitive free market character of our health care system would be radically transformed into a top down, highly centralized regime. It is clear that the proponents of this legislation want to go far beyond our shared goals of making health care more accessible and affordable for all Americans, and increasing the number of individuals who have adequate health care insurance.

We could accomplish both of these important goals without 17 new taxes or a single new bureaucracy. But the goal of the bill before us is not increased coverage but increased control; I repeat, not increased coverage, but increased control, Government control. The manifestation of this control agenda is the mandated, standardized benefits package that would be designed by Federal bureaucrats and forced on every single American citizen.

For the average person who already has insurance, this mandated approach is a sure way to increase the cost of health care. Many Americans will see their premiums rise dramatically to compensate for the added benefits they must purchase in a compulsory one-size-fits-all package. For many middle-income families, the cost of health insurance will balloon even more under the Mitchell bill's community rating provision. The bill stipulates that premium rates may vary only by family size and by age. Lifestyle habits cannot be taken into account. Geographic location cannot be considered, and no incentives are offered to use services in a responsible, cost-efficient manner.

Can you imagine what would happen to automobile insurance rates if insurers could not take driving records into account? That is essentially what this bill does. It charges the mild-mannered Sunday driver the same rate as the drag racer with three drunken driving convictions.

Moreover, the bill requires all cost differences to be phased out by the year 2002. As a result, younger, lower-income families will be hit the hardest as their premiums skyrocket to subsidize coverage for older and frequently wealthier Americans.

The other side of this legislation's control agenda is the burden it puts on small businesses, as well as their employees. Under the Clinton-Mitchell bill, every employer must provide a choice among three Government-designed plans. Keep in mind that the bill does not require choices among benefits packages, but rather choices of how to pay for the plan. This three-option requirement will add considerably to the administrative costs that businesses will face in offering insurance.

Many businesses today are using an insurance funding mechanism called self-insurance to keep their costs down. The Mitchell plan bans self-insurance for companies with less than 500 employees. Some predict that 400,000 businesses will be impacted by this provision alone.

For example, I recently heard from an independent broker in Fort Mitchell, KY, among whose client is a self-insured steel mill with just under 500 employees. He told me that the administrative cost of this plan, the Clinton plan, is less than 4 percent of the plant's total cost. But by prohibiting this company from self-insuring and

forcing it to offer three different plans, this legislation will add hundreds of thousands of dollars to the annual cost of providing health care for its employees. Basically, this company and thousands like it will have only two choices: cut wages or cut work force. That is the painful decision that employers all across America will be faced with because of this bill.

In general, however, Americans have relatively few decisions to make under the Mitchell bill because the Federal Government will make most of the decisions for them, at least as they pertain to their personal health care.

The most powerful and intrusive monolith envisioned by this legislation is the National Health Benefits Board. This board would have the authority to unilaterally decide what medical services Americans should receive.

Just looking at the section on the Board in the bill, as you can see, this is not exactly a small bill:

A, the Board shall be authorized to establish a criteria for determinations of medical necessity or appropriateness; B, procedures for determinations of medical necessity or appropriateness; and C, regulations or guidelines to be used in determining whether an item or service, under categories of items and services described in another section, is medically necessary and appropriate.

Suffice it to say, Mr. President, this is a very powerful Board. This National Health Benefits Board is going to have enormous authority.

Federal bureaucrats ensconced in their marble-lined office suites will be making the most personal, life-or-death decisions for each and every American family, stamping out cookie-cutter health plans as if they were just another mass-produced widget. Not only will this board have unprecedented powers over every single American citizen, it will also be completely unaccountable to those who are impacted by its decisions.

The members of this health care junta will be unelected and by the terms of this bill, they will also be exempt from the Federal Advisory Committee Act. The Federal Advisory Committee Act establishes some basic management and oversight criteria for commissions to keep them from becoming a law unto themselves. Coincidentally, it is the same law that Hillary Clinton's health care task force may have run afoul of, and that issue is now the subject of intense litigation.

Under the Federal Advisory Committee Act, each and every Federal Commission must be rechartered every 2 years. They have to be rechartered every 2 years. I understand, however, that this bill takes the liberty of exempting the National Health Benefits Board and its companion, the National Health Care Cost and Coverage Commission, from such troublesome obligations. Under this bill, these faceless agencies are established as permanent—I repeat, permanent—fixtures on the bureaucratic landscape. So what we have is an all-powerful Federal agency, created through a process that may have violated the Federal Advisory Committee Act, and which is, itself, exempted from the very same accountability and safeguards. You can say one thing about this bill: it sure is consistent.

It is important to note here that this National Health Benefits Board, which is totally unaccountable to the American people, will be easily accessible to special interest lobbyists who want special treatment for their clients.

But there are a few things this Jabba-the-Hut board will not be able to do. For example, it will not be able to authorize medical savings accounts, which are a flexible and innovative way for Americans to finance their medical needs. That is because medical savings accounts are not an option under this legislation. That is really too bad, because experience shows that people who have medical savings accounts tend to become more cost conscious about the services for which they are paying.

This bill also does not allow self-employed Americans, like most of our Nation's farmers, to deduct all of their health costs from taxable income. The bill does raise the deduction to 50 percent, but that hardly amounts to equitable treatment for those in this country who are self-employed. I had supposed that equitable treatment was one of the goals of real health care reform.

Mr. President, one should not conclude, however, that this bill does nothing but take away and restrict and limit and reduce. It does all of those things in spades, but it also vastly increases opportunities for one very special group of Americans: lawyers.

Lawyers are going to love this bill, Mr. President. While many Americans will be heading toward the unemployment line as a result of this bill, such as the employees of the steel mill in Kentucky I talked about earlier, the lawyers of our country will be heading to the courts in droves and laughing all the way to the bank. Medical schools will be heavily regulated under this bill, with a Commission on Medical Education breathing down their necks, while law schools will not be able to turn out lawyers fast enough to meet the demand for litigation.

Let me pause on that point. This legislation's ham-fisted regulation of medical schools throughout the country stands by itself as a monument to congressional hubris. What we are saying through this particular provision is that the Government knows better than all the health care educators and administrators in America. We up here in the Government know better about this than you educators and administrators. We are going to fix it for you. We are saying to all those aspiring to be health care professionals: Forget your dreams, forget your desires; the Government can tell you what to do from now on. We are going to be in charge of your life if you are going to be a health care provider. We will decide for you.

This provision does not belong in a bill that is being considered in what is usually thought of as a free country. I can only imagine what the response would be if we had a provision in this bill that contemplated regulating the numbers and specialties of lawyers. Imagine that, Mr. President. Imagine what the reaction would be if we had provisions in this bill regulating the numbers and the specialties of lawyers. There would be great breast-beating and stirring speeches, not to mention intense lobbying by the American Trial Lawyers Association, all arguing the point that such a heartless provision would deny people the one thing they need most: legal services. Legal services. What if some national commission discovered there was a shortage of corporate tax lawyers in the Rockies? Imagine that—a national commission decided there was a shortage of corporate tax lawyers in the Rockies. Would we then use the heavy hand of the Government to force some of those Gucci loafers out there into the Rockies?

As it stands, this bill is very good to lawyers. It will employ lots of them and compensate them quite well. A little advice to you parents who may be watching: if this bill becomes law, send your kids to law school, not medical school. Leaving aside possible legal claims for fraud, medical malpractice, and privacy violations under this bill—now listen to this—this legislation will create no less than 16 new varieties of lawsuits, Mr. President. Just what our country needs, some new causes of action to pursue in the courts of America. We will have a shortage of lawyers. We will need to produce new lawyers, and we will have new causes of action and go out and clog up the courts of America. If you think that is what America needs, by golly, you will love this bill. It may ruin your health care, but this may put an extra BMW in the garage of every enterprising lawyer in America—maybe two BMW's in the garage of every enterprising lawyer in America. Well, at least somebody will benefit from this thing.

Of course, we are already paying an enormous litigation tax on most goods and services we buy, including health care.

Let me say that there was an article today in the New York Times on this question of increased lawsuits under this bill, entitled "U.S. Judges Warn of Health Lawsuits," written by Robert Pear.

There is great concern among the judges who have to wrestle with all of

this increased litigation and the impact of this legislation.

I ask unanimous consent that today's New York Times article entitled "U.S. Judges Warn of Health Lawsuits" be printed in the RECORD at this point.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

[From the New York Times, Aug. 15, 1994]

THE COURTS: U.S. JUDGES WARN OF HEALTH LAWSUITS

(By Robert Pear)

WASHINGTON.—The top policy-making body for the Federal courts has expressed concern that health care bills pending in Congress would generate a flood of litigation by people trying to enforce new rights to medical benefits and insurance payments.

The judges said they were worried that many of those disputes would end up in Federal courts.

The organization, the Judicial Conference of the United States, took no position for or against the legislation, which is intended to control health costs and widen access to health insurance. "Policy decisions concerning health care reform are properly within the province of the other branches of Government," it said.

But the judges noted that Federal courts were already inundated with drug cases, which have caused delays for civil cases in many regions. The anti-crime bill now pending in Congress would give Federal courts jurisdiction over many additional offenses, including gang violence.

The Judicial Conference laid out four principles that it said would guarantee that disputes over health benefits were resolved quickly and efficiently, without clogging Federal courts. In general, it said, these disputes should be handled through administrative proceedings and then, if necessary, in state courts.

President Clinton's health care plan and the bills offered by the Democratic leadership are, in many ways, inconsistent with the judges' recommendations. For example, the bills would give consumers more immediate access to Federal courts than the judges consider appropriate. But these provisions have drawn little attention for lawmakers.

MORE LAWSUITS?

In several decisions over the last decade, the Supreme Court has severely restricted the rights of consumers to recover damages when their claims were improperly denied or delayed by insurers.

Senator Howard M. Metzenbaum, Democrat of Ohio, said, "It's ridiculous to suggest that the legal floodgates will be opened merely by giving people the right to sue if they have been wrongfully denied badly needed coverage."

Gwen Gampel, president of Congressional Consultants, a health care consulting company, said the experience of Medicare suggested that the Federal courts would not be flooded with new lawsuits.

But Barbara J. Rothstein, the chief judge of the Federal District Court in Seattle and the chairwoman of the Judicial Conference subcommittee on health care, said any bill guaranteeing a right to health care or health insurance would increase litigation.

"It could have a drastic impact on the courts," she said in an interview today. "That's what we're concerned about."

Judge Rothstein, who was appointed in 1980 by President Jimmy Carter, said that if the courts were overwhelmed with new cases, people with urgent medical needs would be unable to have their claims resolved promptly.

ADVICE FROM JUDGES

In its statement of principles, the Judicial Conference said:

"The full exhaustion of administrative remedies for benefit denial claims should be a requirement for any health care legislation. Claimants should not be permitted to bypass administrative remedies and to proceed directly into a court.

"Following the exhaustion of administrative remedies, and consistent with the general principles of federalism, state courts should be designated as the primary forum for the review of benefit denial claims.

"Traditional discrimination claims and actions should be handled differently from benefit denial claims based on issues such as medical necessity.

"To insure the effectiveness of the enforcement provisions of any health care legislation, it is critical that sufficient resources be provided to the responsible administrative and judicial entities."

The same principles were endorsed this month by the Conference of Chief Justices, representing the top judges of the nation's state courts. The group said many state courts were already "struggling with inadequate resources to meet the demands of ever-increasing caseloads."

The bills proposed by President Clinton, by the Senate majority leader, George J. Mitchell, and by the House majority leader, Richard A. Gephardt, would allow consumers to go into Federal courts to challenge the denial of health benefits. Consumers could pursue their claims in mediation proceedings or in administrative hearings at complaint review offices, but they would not have to use such alternatives.

The bills would also permit consumers to sue health plans, state governments and the Federal Government for failure to carry out duties established by the legislation.

The bills generally say courts should take such cases "without regard to whether the aggrieved person has exhausted any administrative or other remedies that may be provided by law."

Victims of discrimination could file Federal or state lawsuits to get compensatory damages, punitive damages, punitive damages and injunctions. Plaintiffs could also seek "reasonable attorney's fees" at the prevailing rates.

Under the Mitchell and Gephardt bills, thousands of community health centers, public hospitals, family planning clinics and doctors in inner-city neighborhoods would be designated "essential community providers," and health insurance plans would generally have to sign contracts with them. An essential community provider "aggrieved by the failure of a health plan" to obey this requirement could file a lawsuit in Federal or state court to compel compliance and to recover damages.

DIARY—HEALTH CARE DEVELOPMENTS

Yesterday: After a day of long Republican speeches and Democratic rebukes, Senator George J. Mitchell, the majority leader, threatened to keep the Senate in session 24 hours a day starting tonight if Republicans do not allow the first votes on amendments to his health care bill.

Congress: Senator Bob Packwood of Oregon, who is orchestrating the Republican opposition on the Senate floor, contended that Mr. Mitchell had promised that senators "would not be rushed." Republicans denied that they were filibustering, although many of them spoke for hours. Mr. Mitchell said that if by this evening, no vote had taken place on an amendment to bolster private coverage for pregnant women and children, "then the Senate will remain in continuous session thereafter, through the evening; through the night."

White House: A doctors' group has rejected a proposed settlement in a lawsuit over whether the Clinton Administration's 1993 Federal health care task force must make its records public. Charles McDowell Jr., president of the doctors' group, the Association of American Physicians and Surgeons, said in a brief Monday that its board of directors voted 13 to 4 reject a settlement. He asked a Federal judge to delay further action on the case.

Mr. MCCONNELL. We already pay an enormous price for the litigation under today's laws without adding these 16 new causes of action that are going to be made available under this legislation before us, if it passes. Just taking a look at the situation today, we have a chart up here called "The Price of a Suit." We are not talking about a suit of clothes, but the price of a lawsuit. Experts have calculated that hidden litigation tax for insurance, lawyers, and trials built into the price of consumer goods today.

Mr. President, we are not talking about what is going to happen under this bill. Under this bill, we are going to get 16 new causes of action. This is going to be a two-BMW bill for every lawyer in America.

For an 8-foot aluminum ladder, the average retail price today is $119.33.

Now the true cost of that ladder is only $94.47. The litigation tax is $23.86.

Picking out a couple of products here that are more related to the health care debate which we are having here in the Senate, let us take a look at a heart pacemaker. The average retail price is $18,000, but the true cost $15,000. Mr. President, that is a $3,000 litigation tax on every heart pacemaker, and that is today. That is before we get into the 16 new causes of action created under the Clinton-Mitchell bill.

A motorized wheelchair, average retail cost $1,000, true cost $830, $170 litigation tax on a motorized wheelchair.

Tonsillectomy—let us pick out two more health care items here—doctor's fee, average retail price $578, true cost $387, a litigation tax of $191. So of the doctor's fee on a tonsillectomy of $578, $191 goes to the lawyers, the litigation tax.

Let us look at a 2-day maternity stay: $3,367, for 2 days in the hospital, but, Mr. President, the real cost is only $2,867. A $500 lawyer's tax, litigation tax of $500 on a 2-day maternity stay.

Mr. President, that illustrates the nature of the problem today. Certainly, what we need in this country are a few more causes of action. Certainly, what we need in this country to be more productive is a little more litigation. If

you think America has a problem because it has too few lawyers, you are going to love the Clinton-Mitchell bill, a boondoggle for lawyers if one ever existed.

Looking at the Clinton-Mitchell bill, section 1602 of the bill—now we cannot be sure that the current version of the bill lists this provision as section 1602 because there have been several different versions floating around here the last few days. It could be that the reason for all these different versions is to show America how efficient health care is going to be after it has been redesigned by Congress and run by the Government.

Anyway, this provision, if it is still called section 1602, adds a number of new protected categories to the traditional discrimination classifications of race, sex, national origin, religion, age and disability. Those are the traditional categories, but we have some new ones here.

The result is that a person could bring a lawsuit against his or her employer, or against a health plan or provider, or even against a State, alleging discrimination on any of the following additional bases.

We just outlined the litigation tax today on a number of different products, many of them health-care related. But under the Clinton-Mitchell bill, there will be new causes of action possible in the following categories: a plaintiff could allege discrimination based on language, based on income; based on sexual orientation; based on health status; or alleging discrimination based on anticipated need for health services.

Counting these up, that is five new causes of action right there alone, Mr. President, five new causes of action.

The lawyers are out there licking their chops right now just thinking about the potential. As I said, it is not going to be one, but it is going to be two BMW's per garage for every plaintiff's lawyer in America. And, of course, the Clinton-Mitchell bill gives access to any court, any court Federal or State, for anyone to bring a lawsuit alleging discrimination.

Now, there is no doubt that every employment decision in America will be affected by this provision. In that regard, section 1602 is really a civil rights provision, and we should not be using health care reform to change well-established civil rights laws.

Although this bill radically changes discrimination laws in a way that will generate a lawyer's feeding frenzy, there is one large area of the law where the Mitchell bill quite literally turns the clock back, and that is medical malpractice.

In the last several years, there has been enormous progress among the States in ensuring fair compensation to victims of medical malpractice, while at the same time curbing the excesses of malpractice litigation, which we all end up paying for.

This bill guts those important reforms. It turns back the clock on malpractice reform by preempting State law and effectively repealing the work of over 20 States to get health care costs under control.

This is unacceptable, Mr. President. It is antireform, and it must be reversed.

I have heard for many years opponents of any kind of tort reform at the Federal level say that it ought to be left to the States, suggesting that the States should be free to pursue this area if they chose on a State-by-State basis, but this takes that away, Mr. President. It takes away that innovation and says you cannot legislate in this area any longer.

Instead of doing this, Mr. President, we need to build upon what the States are doing, not turn back the clock on their progress. For example, we should abolish the collateral source rule to stop wasteful double recovery. We need controls on sky-high punitive damages. We need to modify joint and several liabilities so that those who are responsible for the harm pay their fair share.

Mr. President, I am sure that every Senator wants injured patients to be fully and fairly compensated for the harm they suffer. That is not in debate. We all want a system to deter negligence, and we all want the few incompetent health care providers that exist to be held accountable. But the bill before us merely perpetuates and even spreads the worst in the current malpractice system. Clearly, we can do better than that.

That brings me to my final point about how we ought to go about health care reform. My view is we should be focusing how to fix our current problems and how to reduce costs, not how to expand Government control and bureaucratic interference.

As I said at the outset, our system is the best in the world because of its reliance on private sector competition and market driven innovation. The Clinton-Mitchell bill, on the other hand, will move American health care in the exact opposite direction. It will create a system where bureaucrats, politicians, and lawyers have more authority over health care than doctors, nurses, and researchers—let alone the patients. As government control expands under the Clinton-Mitchell bill, the incentive—as well as the power—to cut costs, improve care, find new medicines, and treat patients in a personal manner will decrease by inverse proportion.

We just need to look across our northern border, or over the Atlantic to our European neighbors, to see the effects of Government-run health care. These results are not something I believe our country wants to emulate. Citizens are often taxed at 50 percent or more of their income. Structural unemployment persists at 10 and 12 percent. There are waiting lines for medical services, and there is rationing of the use of medical technology that can detect diseases and save lives.

We have all heard these numbers and facts, but let me put a human face on the results we can expect from a Government-run health care system on living, breathing people:

A young woman from Scottsville, KY, the daughter of a friend of mine, was spending a semester abroad studying in London England, this past winter. Unfortunately, she awoke in the middle of the night with excruciating abdominal pains. She went to the hospital, was given medication, and at the time was very impressed that everything was free. However, her condition deteriorated; so she went to a local health clinic 2 days later. She was examined by a doctor whom she described as overworked and preoccupied with other problems. This doctor gave her more medication, but still her condition deteriorated.

Waking in the middle of the night with a fever, chest pain and labored breathing, she decided to use the house call service which the National Health Service requires of all its doctors. Despite the house call, she became more and more ill, and decided the next morning to return to the second doctor she had seen. By this time, her very worried father had contacted my office to ask whether we could be of any assistance.

My office contacted the United States Embassy and obtained a list of several private doctors for the family to call. The young woman quickly made an appointment with one of these physicians, who soon diagnosed the cause of her illness and treated her properly.

Let me read an excerpt from a letter which this young woman sent me afterward—because I think she speaks very well to the issues we must resolve in this debate. That is what she had to say:

> Senator MCCONNELL, I always thought it might be a good idea to have free medical coverage for all citizens. And in an ideal world, it could be. But the reality is that socialized medicine is not successful. It leads to crowded clinics and hospitals, with overworked and underpaid physicians and staff who cannot spend enough time with any one patient. Yes, I eventually did find a good doctor, but I had to pay much more for him than I would have in the U.S.. My experience has led me to the conclusion that socialized medicine, if adopted by [our country], will result in a society of doctors who do not have the time, money, or interest to spend enough time with their patients.

I also heard recently from the president of a hospital in London, England, who shared his perspective on our struggle over health care reform. We would do well to listen to this voice of sober experience. He writes:

If a plan passes that has a global budget, or contains price controls, a National Health Service-style health care system will eventually evolve in the United States. I, for one, would not like any member of my family being told that they cannot get a service, or will have to be put on a waiting list stretching more than a year because of lack of resources. The market . . . has shown time and time again that it is far better at determining prices and directing capital to where it is needed. The government's record is abysmal in this regard.

Those are just two glimpses of how government-run health care has fared in other countries. Unfortunately, examples of the disastrous consequences of government-run health care can be found right here in America, too.

As most of us are painfully aware, the Federal Government operates its own medical care system for our Nation's veterans, through the Veterans Administration. I say painfully aware, because many of us in this body devote a lot of time and energy on behalf of veterans in our states who simply cannot get the care they need without long waits and pointless bureaucratic hassles.

I remember a few years ago, to give an example, my office was contacted by a Vietnam veteran who had lost his leg in combat. He desperately wanted a replacement leg, so that he could work and enjoy a whole life again—but the VA made him go through one bureaucratic hoop after another. At one point during his ordeal, he heard from some other veterans that my office had a good track record in helping people like him get results from the VA. So he called my office and we went to work.

After a lot of calls and letters back and forth, we eventually got the VA to give this man a replacement leg. In the process, we discovered that one factor in the VA's refusal to help this gentleman was plain-and-simple retribution: The VA saw this patient as a troublemaker, someone who rocked the boat—and for that reason they decided to jerk him around on medical treatment that he needed.

Is that the kind of health care system we want for all Americans? Where faceless bureaucrats can get even with patients who raise too much of a fuss about the health care they are getting—or not getting? And as much as I was pleased to help this veteran and all the other veterans who call me, do we really want to create a health care system where you need to have a U.S. Senator get involved before you can get the medical care you need?

Imagine that. Every American, in this new world brought to us by the National Health Benefits Board, has to call his Senator to get his or her Senator to intervene with the Government to get the care that is needed.

Let me give you another example of what I'm talking about. I recently heard from another veteran in Madisonville, KY, who had contacted the VA office in Louisville to request a medical examination for back pains that he was experiencing due to an injury he had suffered on duty. The VA told him that he could not simply make the request over the phone; he had to put it in writing.

So the gentleman wrote a letter, and one month later, he still had not received a response. So he called again and the VA told him to wait for 30 more days. A month and a half later, he still had not heard. Of course, his back was causing him intense pain throughout this entire ordeal. So as a last resort, he contacted my office and now we are working to help this man schedule an appointment for an examination.

He is just trying to get an appointment for an examination and he is in intense, excruciating pain—brought to you by Government medicine.

Is that where health care in America is headed? When you want an appointment, will you be able to just call your doctor—or will you need to wait for months on end and then, in desperation, call in your U.S. Senator.

The kind of shoddy treatment I have been describing is happening in this country today to our veterans—men and women who are courageously serving our Nation. Yet they wait over 2 months to hear about a request for an appointment.

This is the kind of garbage that is going on today—in America—in a Government-run health care system. Long waits. Faceless bureaucracy. Retribution against patients who dare to complain. So I would say, Mr. President, if we really want to pass meaningful health care legislation this year, we ought to try to reform the VA health care system. That would be a good place to start, rather than spread it to the rest of the country.

I can hear the proponents of this legislation protesting that I am comparing apples and oranges; that the VA is really a single-payer system, whereas their bill makes everybody pay through the nose.

The problem with this legislation is not just who pays and how much they have to pay, but who regulates. This bill gives unprecedented, plenary powers of regulation to the Federal Government. Unprecedented.

If it becomes law, the Government will effectively control every single important facet of our health care system. Directly or indirectly, it will regulate the financing of health care decisions about benefits, costs of policies and reimbursement rates for all medical services.

Under this legislation, the Federal Government will even decide whether a physician may enter a particular speciality and which geographic areas should be entitled to certain kinds of health care providers. So make no mistake, this may not be a single-payer bill, but it is without question a single-regulator bill—a single-regulator bill—and the end result is likely to be just as disastrous.

We can reform our health care system without giving the Government monopolistic control over one-seventh of the economy and over a very important and extremely personal part of each of our lives.

We can reform health care and actually make it better instead of less responsive, more expensive and more bureaucratic. We could, for example, make some simple changes in the way health insurance is marketed—to improve access and guarantee that coverage is portable and renewable. We could restrict the practice of exclusion from preexisting conditions and limit the ability of insurers to drop policy holders like a hot potato after they incur some costly illness or accident.

We could reduce health care costs enormously in four easy steps: enact meaningful medical malpractice reform; create private sector purchasing alliances that are truly voluntary; simplify administrative procedures; and allow the market to eliminate services that consumers, rather than bureaucrats, do not want.

We can help family farmers and others who are self-employed by letting them deduct 100 percent, not 50, but 100 percent of their health insurance costs. All of the measures I have described, as we all know at this point, are in the Dole-Packwood bill. They almost certainly are supported by the vast majority of Americans.

Yet, we are debating today a bill that is largely despised—despised—if not feared by most of those we represent. They hate it. We know that because they are calling our offices and we see the polls. So we ought to stop listening to the special interests, stop listening to the White House political shop, stop listening to the party bosses, and start listening to the calls we are getting from home, listen to the voters, listen to the families in our States.

They are telling us by an overwhelming majority that they do not want this bill. They do not want a Government takeover of their health care system, whether it be single payer or single regulator or whatever. They want control of the health care decisions that affect them, and they do not want to give that control away to a faceless, passionless bureaucracy in Washington.

So we better listen to our constituents' views on health care now or we will certainly hear from them loud and clear in November.

Let us pass a bill that brings real reform to health care without letting Big Brother in the door.

So where does that leave the bill before us? We will need to diagnose it first to answer that question.

First of all, we observe that the bill is plainly overweight. One could even

say obese. In fact, the bill suffers from legis-sclerosis, a condition which is caused by unhealthy levels of bureau-cholesterol. It also shows symptoms of "Clintonitis," such as swollen entitlements and acute taxation.

The bill has inflamed constituents, and according to samples that have been taken very recently, it appears to have a dangerously low vote-count.

Evidently, the attending Senate Democratic physician has attempted to treat the patient with heavy doses of "mandatol" with its predictable side effects of impaired autonomy and severe economic contractions.

The other drug which is being administered liberally is "spenditol," which as we all know, merely aggravates the patient's fiscal deficit disorder.

So what course of treatment should we prescribe for this ailing piece of legislation? First, we should note that its intended beneficiaries, the American public, have hung a large sign on the bill which reads: "Do not resuscitate."

That being the case, the first thing we should do with this bill is put it on a strict diet. We need to reduce the intake of bureau-cholesterol, cut out all the administrative fat, and help it shed some of its socialized cellulite. If that does not work, we may need to consider major surgery: a "mandate-ectomy," for example. Otherwise, this flabby bill is going to keel over under its own weight.

Mr. President, I yield the floor.

ORDER OF PROCEDURE

Mr. MITCHELL. Mr. President, I ask unanimous consent that the Senate vote on or in relation to Senator DODD's amendment No. 2561 at 6:30 p.m. this evening with the time prior to that vote equally divided in the usual form, and that no amendments be in order to Senator DODD's amendment.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. MITCHELL. Mr. President, the time will be equally under the control of the Senator from New York and the Senator from Oregon.

Mr. PACKWOOD. That gives us about 7 minutes apiece roughly.

Mr. MOYNIHAN. It means the Senator had better hurry.

Mr. PACKWOOD. I yield 3 minutes to the Senator from Kansas.

The PRESIDING OFFICER. The Senator from Kansas [Mrs. KASSEBAUM] is recognized.

Mrs. KASSEBAUM. Mr. President, I rise to discuss for a few moments the amendment put forward by the Senator from Connecticut [Mr. DODD].

It is hard to argue against this amendment because who here does not want to offer what health services we can to pregnant women and to children? No one has been more committed to this issue than the Senator from Connecticut.

But, as my colleagues know, women's and children's benefits are included in the standard benefits package. Under the Mitchell bill, all insurers would be required to offer such benefits beginning in 1997. The Dodd amendment would speed up required coverage for prenatal and well-baby care. Given the poor health status of many of our Nation's children and the high infant mortality rates in many areas of the country, it is difficult at first glance to oppose the amendment.

However, this amendment, I would suggest, goes to the core of the question of who should design and arbitrate benefits package issues? Should it be Congress? We have found it impossible to do that in any reasonble or measured way. The Senator from Minnesota [Mr. DURENBERGER] made an eloquent statement last evening regarding the endless controversies we invite when Congress attempts to define the specific benefits to be offered. Not only can Members of Congress never say "no" to any particular benefit, but we also quickly find ourselves in a situation where new technologies and procedures can render our decisions obsolete.

I am concerned that the Dodd amendment will be just a preview of the future congressional tinkering with and expansion of the benefits package. I have serious reservations about this precedent, Mr. President. Where does it end? Should we move up earlier mammograms to the front of the line? Should we move up prostate cancer screening to the front of the line? There are serious health concerns in preventive medicine that we should consider. Do they not deserve priority as well?

I support a standard benefits package. But that is not what this debate is about. This debate is just the beginning of a process Congress is ill-suited to handle.

Like many others, I have advocated that an independent, nonpolitical commission should be responsible for designing a benefits package which makes sense and which we can afford.

On the surface, the Dodd amendment has enormous appeal. We cannot, however, risk having that appeal blind us to the precedent it sets and the serious questions that remain regarding how a benefits package should be shaped.

I yield the floor, Mr. President.

The PRESIDING OFFICER. Who seeks recognition?

Mr. MOYNIHAN. I yield 1 minute to the distinguished Senator from Massachusetts.

The PRESIDING OFFICER. The Senator from Massachusetts [Mr. KENNEDY] is recognized.

Mr. KENNEDY. Mr. President, I was particularly interested in the comments by my good friend from Kansas, since Kansas was the second State to have legislation that was similar to that which we are considering this evening and was a real leader in terms of children's issues.

Mr. President, I have just two thoughts. This is an important moment for the children of America. Under the leadership of the Senator from Connecticut and others, we start this great debate on national health putting children first, those that are the most vulnerable who have been left out and left behind. That is point No. 1.

Second, Mr. President, this is a good moment for the American people, for at last we are beginning the serious process of the serious debate on national health insurance. It is appropriate that children are first, and it is appropriate that we begin this debate with meaningful votes on the direction that we are going to take on health care for all Americans.

I yield.

Mr. PACKWOOD. I yield 2 minutes to the Senator from Minnesota.

Mr. DURENBERGER. Mr. President, I agree with my colleague from Kansas and my colleague from Massachusetts, if that is possible. I think we are debating what is best for women and children in this country.

I regret that I made this argument last night at an hour which probably was not available to a lot of people. But I think the argument is fairly basic. Is the best care, both prenatal care and well-baby care, that which is determined by the doctor and the health plan in conjunction with the doctor, the obstetrician or the pediatrician? Or is it going to be determined by the Secretary of HHS? I do not have a problem with the first part of this amendment because it is basically what has been debated and argued here in the last 3 or 4 days. And that is that we ought to cover clinical preventive services, including prenatal care, well-baby care, immunizations for pregnant women and children. We all agree on that. The problem for me is when you direct the Secretary of HHS by July of next year to have come up with a schedule of the routine services that are going to be required in every single health plan in America for every single child and every single mom in America.

They talk about the Academy of Pediatrics. I tell you, the Academy of Pediatrics will tell you it depends on the family history of the child, on whether there is a history of disease, it depends upon some of the cultural background, and it depends on a whole lot of factors as to what is the best care in a particular case. There is no way that the Secretary of HHS is going to be able to promulgate by regulation what service is the most appropriate in a given case for every kid. You cannot have one standard for every pregnancy and every child in America.

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. MOYNIHAN. On our time, I would like to state that New York is

one of the States which already has the provisions of the Dodd amendment, and they should be available to all Americans in every State.

I yield 1 minute to the undaunted champion from Pennsylvania [Senator WOFFORD].

Mr. WOFFORD. Mr. President, Senator DODD worked with women and children in the Dominican Republic in the Peace Corps, and it is very fitting that he has carried that work forward to the American people and American children and American women sooner rather than later. That is the lesson of this amendment. Let us not be proud of dragging this process out into the next century. Let us be proud of how we find the ways and means to give health security and preventive health care to children sooner rather than later.

This amendment was not so complicated. We were able to get to work on it. It is a page and a half. Implemented not later than July 1, 1995. Harry Truman, who started this fight, would be proud of us. Remember his words:

> Where there are differences remaining as to the details of the program, we should not permit these differences to stand in the way of our going forward. They should be thrashed out with honesty and tolerance, as is our democratic fashion. We should enact the best possible program and then all of us should get behind it and make it work.

The PRESIDING OFFICER. The time of the Senator has expired.

Who yields time?

Mr. PACKWOOD. I yield 2 minutes to the Senator from Rhode Island.

Mr. CHAFEE. Mr. President, first, I want to congratulate the Senator from Minnesota. I share his sentiments. What are we trying to do here? The goal is to cover all of these services in the uniform benefit package that we are going to come up with. I do not think we want to be so specific that what is put into regulation then has to be changed in the following year.

I suppose the proponent of the amendment would say that this is just for during the interim period. This will come out by July of 1995. But we all know that once we start down that track, once the Secretary of HHS comes out with this very detailed schedule—and everybody is familiar with this, and I presume it has been read before—she shall establish a schedule of periodicity that reflects—and so forth and so on. This is just the path I do not think we want to go in. To me, it is reminiscent of Medicare. In Medicare we have every possible contingency covered by regulation, and it is chaotic. I have had a hand in all of that. I think I mentioned in the remarks I made the other evening that you find the bizarre situation of Senator CHAFEE and Congressman PETE STARK, both in part of the conference on Medicare at 2 a.m. in the morning deciding in some remote part of this Capitol who will get paid for reading an EKG. I am totally—and I might speak for Representative STARK in the same manner—incompetent to do that. We were beyond our realm on that. That is not in our job description.

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. CHAFEE. Mr. President, I just want to say that these are decisions that should be made by doctors, and the plan, and by individuals, and not by the Secretary of HHS.

The PRESIDING OFFICER. Who yields time?

Mr. PACKWOOD. How much time do we have left?

The PRESIDING OFFICER. There are 21 seconds remaining.

Mr. MOYNIHAN. I yield 42 seconds to the gallant and learned Senator from Connecticut [Mr. DODD].

Mr. DODD. If you keep talking like that, I would ask you to come to Connecticut and say those words.

Let me just say how pleased I am, Mr. President, that at long last we are finally going to have a vote on this proposal.

Let me repeat for the benefit of my colleagues what the amendment does. It is very simple. It merely says that all private insurance policies—private insurance policies—must include coverage for preventive care for pregnant women, children, and infants as of next July, to expedite and accelerate that coverage. It creates no new Government bureaucracy. It builds on our current system of private insurance to make certain that we start giving our children a good start right away.

Why is this so important? Why is it important to start providing these benefits earlier? I think the facts and statistics, Mr. President, speak for themselves. Every time that a low-birthweight delivery is prevented, it saves between $20,000 and $50,000. Every time a very low-birthweight delivery is prevented, it saves approximately $150,000. Not much more needs to be said.

Clearly, if we can accelerate the coverage of these children by a year and a half or 2 years, we will eliminate significant future costs. We mandate well child care already in 22 States. The Senator from New York pointed out that his State has had this type of program for some time. The first State was Wisconsin and the second, Kansas. These programs were started under Republican Governors, I might add, that insisted that we reach out to children as quickly as possible.

There is a legitimate debate about individual proposals to deal with the benefit package, but I think there ought to be some consensus here about children and pregnant women, that it is in our collective interest to see that we do everything to prevent—not treat but prevent—these problems from occurring.

If we can prevent these health problems from occurring, more promptly and earlier, we all win and all gain. Therefore, Mr. President, I think this amendment is critically important. Of course, I think all of us agree that we must figure out a way to reach the 12 million uninsured children.

I want to stress that this amendment does not create any new Government organization. It is all done under private carriers. HMO programs in this country require this, and have insisted upon it, to their credit.

I believe that Republicans and Democrats, on the very first issue addressed in this body on national health care reform, on the issue of pregnant women and children, ought to be able to come together. We may divide in the days ahead on the issue of mandates, and alliances, and cooperatives and whatever. But on children and pregnant women, let us say to the American people tonight that as far as those citizens are concerned, we unite and stand together to see to it that they will at least get the basic kinds of health care coverage that they deserve and need to make this a stronger and healthier and better Nation.

Mrs. HUTCHISON. Mr. President, I rise to oppose the Dodd amendment. This amendment would have the effect of changing insurance laws throughout America, starting immediately, preempting State laws and requiring every person to take this coverage regardless of whether or not they will have children in their families. It is a mandate on people to take a standard benefits package whether they need it or not. This takes away the freedom of choice, and the cost requirements are a tax which will have to be borne by each individual and his or her employer. This is what is wrong with a standard benefits package mandated by the U.S. Congress, and why I do not support it in the Mitchell bill.

Mr. THURMOND. Mr. President, before beginning my statement on this bill, I wish to acknowledge the efforts by the President and Mrs. Clinton to focus the Nation's attention on the need for health care reform. While they have worked very hard to reach this point, I cannot support the far-reaching plan which we are now considering. Hopefully, during debate on this issue, we can agree on reforms which will improve our health care system without burdening our society and economy.

We all agree that our health care system needs repairing. Our primary goal should be fixing the current system without losing the advantages of choice and quality coverage we presently enjoy. We must not forget that the American health care system is the envy of the world. Foreign leaders and dignitaries come here for treatment because their own systems simply do not provide the same quality and advanced care.

Last year the United States spent approximately $900 billion on health care.

This is 14 percent of our gross national product. Obviously, any reform in health care will have a large impact on our economy. However, it is our responsibility to assure Americans that any reform will benefit the finest quality health care system in the world.

Mr. President, I believe the best starting point for health care reform is prevention. If Americans have ample information and incentives concerning preventive health care, many of the health care problems can be avoided. Proper diet, reasonable exercise, self-discipline, and an optimistic attitude toward life promote health. It stands to reason that such sensible measures are cheaper and cause less suffering than curative medicine.

Prevention programs are especially needed in the maternal and child health fields. The lack of prenatal care causes thousands of easily avoidable birth defects each year. For example, many women who smoke do not realize that smoking during pregnancy may contribute to low-weight births. Also, many Americans do not know that the use of alcohol or drugs during pregnancy may result in a child with fetal alcohol syndrome or addiction. Simply providing obstetrical and gynecological services can prevent these and other infant health problems.

We can save an immeasurable amount of suffering if we simply promote and practice preventive health care, starting with prenatal health and continuing throughout the life of a child.

Prevention programs are also needed in the areas of substance abuse and mental health. As you know, the cost to our Nation caused by substance abuse and mental illness are tremendous. In 1990, Americans spent $314 billion on health and social problems created by drugs, alcohol, and mental disorders—$100 billion more than the cost of AIDS and cancer combined. We pay not only in medical care costs, but also in a rising crime rate; an overburdened social welfare system; productivity losses; premature deaths; and emotional suffering that cannot be measured.

The importance of helping those who suffer from addictive and mental disorders is evident. Studies have shown that treatment programs can reduce the enormous social and economic costs of these disorders. For example, half of the patients receiving treatment for schizophrenia, either completely recover or can function with minimal support; thereby cutting rehospitalization rates, preventing homelessness, and improving employment outcomes for those patients.

Mr. President, for every dollar spent on treating someone with substance abuse problems, $11.54 is saved in social costs. For example, the estimated 10 million alcoholics in this country spend two times more on health care than those without alcohol problems.

Costs associated with substance abuse are not limited to health care. Addictive and mental disorders have added to our society's greatest problems: crime, joblessness, and welfare. Therefore, we can not ignore the beneficial effects of prevention and treatment.

Mr. President, there are issues on which I believe we can agree. For example, we should not allow the cancellation of health care coverage because of illness, or allow coverage to be denied because of a pre-existing condition. Further, I believe we all agree that coverage should be portable. If individuals lose their jobs or decide to change jobs, they should not fear a reduction in their health care coverage, nor that they may lose it entirely.

I am pleased that there is some common ground in these areas. Unfortunately, this legislation reaches far beyond these common issues. It creates one of the greatest social spending programs in history. It also creates one of the greatest intrusions into the rights of the States and the rights of individuals.

No one wants to be denied health care when it is needed. However, there are distinct and subtle differences between what is called universal coverage and universal access.

Universal coverage essentially means that the Government will run our health care system. Everyone may have coverage, but at what price? Some of the looming prices include less quality, less access to needed services, less freedom, more government, and more taxes.

Universal access means that a person cannot be denied coverage because of a preexisting condition or on the basis of employment or wealth. It is founded on personal responsibility which means it is not a free ride.

Many Americans are disgusted with the free ride welfare system in place today. Is it because people do not want to help their fellow Americans? I doubt it. We prove time and time again that we are the most generous Nation on Earth. Americans traditionally come to the aid of those in need. Everyone recognizes that some help is needed every now and again. However, people are willing to give someone a hand-up but not a hand-out. That is why people are upset with welfare—it is a handout. It is a self-perpetuating cycle of dependency. The American people are tired of hearing that their hard earned income goes to some wasteful and inefficient program.

Yes, there are problems with our current health system, but they will only be made worse if this plan is enacted in its current form.

I have a number of specific concerns surrounding the Clinton-Mitchell bill. My first concern is the issue of the guaranteed basis benefits package.

The Clinton-Mitchell bill would entitle all Americans to a package of guaranteed national health benefits. This guaranteed benefits package includes mental health services, substance-abuse treatment, and some dental and clinical preventive services. The mandatory package includes not only major medical services, but also incorporates routine eye and ear examinations and even elective abortion services.

The Clinton-Mitchell bill would require every health plan to provide this standardized package of health care benefits. This requirement will take away the consumer's ability to choose benefits. Moreover, as the Government aggressively promotes managed care, the ability of doctors to treat patients according to their independent professional judgment will be severely circumscribed. These limitations will make it difficult for Americans to take advantage of new or specialized medical services.

The National Health Board will set national guidelines for determining which treatments can be provided or upgraded, which treatments are medically necessary, and even how often approved treatments or tests can be conducted. New benefits, including new treatments, medical procedures, or devices used in the treatment, prevention, or cure of disease will have to be approved by the National Health Board, or Congress, before they can be covered in a basic benefit package.

New benefits will be approved slowly and with great difficulty. I am concerned that there will be extended bureaucratic delays and major political debates surrounding any attempt to alter benefits. For medical specialty groups, or groups afflicted with particular medical conditions, the National Health Board and, inevitably, Congress will become the central focus of intense lobbying over the addition or subtraction of medical benefits, further politicizing the health care system.

I believe we can avoid these problems by allowing consumers their own choice of doctor and health care plan. We can do this by ensuring portable, universal access to health care, regardless of pre-existing conditions and without mandating specific benefits.

Another area of concern is the treatment of the system for graduate medical education. I agree that we have a shortage of primary care physicians and providers in America. Many people are concerned that there are too many physicians, that our distribution of specialists is poor, and that there is no government control on training programs. However, we have the best health care system in the world. I believe that is due in part to the fact that we allow our students and medical professional to choose their fields of endeavor and to pursue their careers without interference.

Unfortunately, this legislation will directly interfere with the career

choices our students will make. This legislation directs that National Council on Graduate Medical Education to decide how to cap the physician supply by not allowing students to enter a nonprimary health care training program. This commission will define the goals for specialty mix, the number of residency training positions, and where residency programs will exist.

This legislation dictates that the national council shall ensure that 55 percent of the students in primary care programs will pass. I am concerned that this will lessen the quality of the education received by these students.

I believe we are approaching the shortage of primary care providers from the wrong angle. We should be encouraging our students to pursue careers in primary care. We should not limit the number of positions available in specialized areas.

Mr. President, a third area of concern is the expansion of prescription drug coverage, and the potential for price caps and shortages in this area. There is no question that all Americans need access to affordable prescription drugs. Unfortunately, too many Americans are supporting this plan because they believe it will expand their drug coverage.

They must think this through. At what cost will drug coverage be "expanded"? Some of the costs will surely be: Reduced research, reduced choice of medications—many of our senior citizens prefer to use certain products—premium caps, shortages in drug supply, and taxes.

Mandated Government prices controls or price review boards would penalize pharmaceutical research, and eventually drive companies out of the industry. Recent studies of the pharmaceutical industry indicate that the free market, along with strong safeguards to ensure quality help, contains price increases.

As you know, in 1993, the pharmaceutical industry spent an estimated $12.6 billion on research and development. The Office of Technology Assessment estimates that in 1990 the average cost of research and development for each new drug marketed in the United States was $359 million.

The best hope for treatment and possible cures for many of the health problems we face today is in the area of pharmaceutical and biotechnology advances. If we try to establish price discipline, we will see a decrease in pharmaceutical research and development, and fewer pharmaceutical and biotechnology breakthroughs.

I am also concerned that the Workers' Compensation Program has been included in this legislation. The proponents of this legislation will argue that it is only establishing a system of data collection and a commission to study whether workers' compensation should be incorporated into health care reform. This is true for the Senate version of this legislation. Unfortunately, it is fully incorporated in the House version. My concern is that the Senate version will be dropped before the conference even begins.

Let me address my reasons for this concern.

As you know, workers' compensation was created over 80 years ago and is the result of a common compact between business and labor. If a worker is injured on the job, the financial burden of an industrial accident is shifted away from the injured worker and charged to the employer. All of an injured worker's medical expenses are covered, and the work-related disability payments are made until the worker returns to the job. In addition, workers' compensation insurers attempt to manage treatment and rehabilitation in order to minimize an injured worker's loss of earning capacity and/or physical function. In return, the injured worker agrees not to sue his or her employer to receive compensation for the injury.

The House's inclusion of workers' compensation in this legislation will jeopardize the current freedom and flexibility of States to experiment with new ideas and approaches to improve the system. A number of States have had recent successes controlling the growth of workers' compensation costs. In the last few years, Massachusetts, Florida, Oregon, New Mexico, and Washington have all undergone efforts to reform workers' compensation. Dozens of workers' compensation legislative proposals are also pending in various State legislatures. Each State has taken a different approach in its reform, and we should not impede this progress.

Mr. President, the goal of workers' compensation is simple: Get an injured worker back to work and normalcy as soon as possible. Much of the success in achieving that goal is due to the fact that insurers and employers who foot the bill for medical care should continue to have significant decision-making authority. The House version will prevent the employer and the State workers' compensation agency from questioning whether appropriate medical treatment is being received. Employers and insurers are concerned about separating the responsibility for medical management from the financial responsibility for cash benefits, and losing control over the medical portion of the workers' compensation premium which amounts to approximately $24 billion a year.

Inclusion of workers' compensation would also eliminate the benefit of experience rating. Experience rating encourages employers to directly influence their premiums by implementing workplace safety programs to reduce the number of accidents among their employees. The integration of workers' compensation would seriously and adversely affect employer safety incentives by moving workers' compensation from an experience-rated to a community-rated system, and the public would bear the cost of an employer's unsafe workplace.

I believe the workers' compensation system is unique in its mission and its approach. I also believe that including it in this reform package would be a mistake. Workers' compensation has always been a successfully State-managed system, and I believe it should remain with the States.

Another concern I have with this bill is the inclusion of the antidiscrimination provisions. Under current law, employers, schools, and places of public accommodation are not allowed to discriminate on the basis of race, sex, age, national origin, religion, or disability. The Clinton/Mitchell bill would add five new categories that have never been considered as protected groups under our civil rights laws. They include: Language, income, sexual orientation, health status or anticipated need for health services.

This language is simply not needed to ensure that there is no discrimination. Section 1002 clearly establishes that all health plans shall "accept all eligible individuals for coverage." There is no room for discrimination in this section.

I believe our employers, health plans, States, and other entities will be exposed to unlimited damages and lawsuits that will further raise the cost of health care and further overwhelm our judicial system.

This is an unprecedented expansion of law. We do not know how broad these new categories are. We also do not know what effect this new expansion will have on our employment policies. Therefore, we must question why these new categories have been included.

Mr. President, as the ranking member of the Senate Judiciary Subcommittee on Antitrust, Monopolies and Business Rights, I have two additional concerns that relate to the antitrust laws.

First, I oppose the attempt in this legislation to repeal the McCarran-Ferguson Act for the provision of health benefits by insurers. This repeal would be bad for both competition and consumers and would interfere with State control over the regulation of insurance.

The repeal applies to "health benefits," which might appear quite narrow, but in fact encompasses many lines of insurance. The term is far broader than mere health insurance, and could cover workers' compensation, homeowners, auto, medical malpractice, and general liability insurance.

Any repeal of McCarran-Ferguson will inevitably lead to a decrease in

competition rather than the increase proponents claim. The insurance industry is now highly competitive with thousands of firms competing for business. Without the ability to engage in certain joint activities, especially sharing of information, many of the smaller companies may go out of business and competition will be diminished.

If McCarran-Ferguson is repealed, I believe it would only be a matter of time before Federal regulation crept in. Federal regulation is generally cumbersome, slow, and unresponsive to local and individual needs, while the State regulation encouraged by McCarran-Ferguson is better suited to the needs and interests of the consumer and the industry. The net effect of McCarran-Ferguson repeal in this legislation is that consumer welfare will not be enhanced. The uncertainties associated with such a change will likely decrease competition as regulation increases, to the detriment of the consumer and the marketplace.

My other antitrust concern is that this legislation makes no attempt to address the many uncertainties of the antitrust laws, which are worsened by health care consolidation under this legislation. Last November, Senator HATCH and I introduced the Health Care Antitrust Improvements Act to establish a framework for adjusting the antitrust laws to health care reform. We have recently modified our proposals to address concerns which had been raised, but continue to pursue the key goal of clarifying how the antitrust laws apply in the health care industry. The purpose is to save money and improve quality in health care, not for the benefit of providers, but for the ultimate benefit of patients and those who pay the bills.

Saving money through lower antitrust costs is achieved by greater antitrust certainty so that fewer questionable cases are brought, by giving more responsibility to the Federal antitrust agencies to determine what conduct is desirable and what is not, and by focusing antitrust enforcement on the areas that truly need it rather than on areas that generally do not.

Quality is improved by removing unnecessary and artificial antitrust barriers that prevent medical providers from organizing themselves to achieve the combinations which can deliver the highest quality of care. The antitrust laws currently chill much desirable conduct by medical providers. This has a negative effect on quality but can be avoided by greater certainty about the applicability of the antitrust laws in the health care field.

In order to permit desirable activities and organization by health care providers, the Hatch-Thurmond provisions direct the Justice Department to develop safe harbors for specific categories of conduct which need not be subject to the antitrust laws. Because of the difficulty in determining where to draw the lines in changing markets, the Attorney General is authorized to review applications and issue antitrust waiver covering individual situations. In addition, our provisions permit health care joint ventures to be disclosed to the Attorney General in exchange for single damages, following the pattern of the production joint venture bill that passed the Congress and was signed into law last year. These provisions establish a framework for adjusting the antitrust laws to changing health care markets, to achieve the ultimate goal of more efficient, higher quality medical services at reasonable prices for the benefit of all Americans.

Finally, Mr. President, perhaps the most pressing issue is that of the mandates included in this bill. This legislation will require each State to submit a health care reform plan to the National Health Board detailing how the State will comply with the Federal rules and regulations established by the Board. The States will have to demonstrate to the Board how they will certify health plans, administer subsidies for individuals and small employers, collect data on health plan performance, and meet Federal quality and management requirements.

There are at least 50 new mandated bureaucracies created under this legislation. I believe the American people can do without more bureaucracy.

Also contained in this legislation are 17 new federally mandated taxes. When you tax someone it means less money in that person's pocket. It means that person has less freedom to do what they wish with their hard-earned income. It often means that person must also try to get by with less money to pay for food on the table, diapers for the baby, the utility bills, or any other necessary expenses.

Mr. President, this legislation sets the goal of coverage at 95 percent. If that goal is not reached, an employer mandate is triggered that requires the employer to pay 50 percent of the costs of an employee's health plan.

The employer mandate imposes additional labor costs on our economy, and when businesses are faced with an increase in labor costs they first look to the employee to make up the difference. This will take the form of lower wages, fewer benefits, and job loss.

What small business is going to want to hire another employee when they are facing a 50-percent tax on health care? That is what it is. It is a tax business. You can call it shared responsibility or employer contribution, but the simple fact is that the Federal Government is directing the private sector to spend its money in a particular way. That is a tax.

Webster's Dictionary includes among its definition of the word tax "to impose a burden on; put a strain on". The employer mandate places an enormous burden on the individuals and businesses of this great Nation.

According to a preliminary study done by the Heritage Foundation, businesses in South Carolina may suffer an additional $806 million a year in additional taxes. That is $806 million that will not go toward creating new jobs or to support existing jobs.

The people of my State do not want a federally imposed employer mandate. The American people do not want an employer mandate. They know it is not good for business and, in the long run, it is not good for the economy.

Many of the proponents will advocate that this trigger will only happen if the reformed free market fails. These advocates say they are going to give business a chance. That is like tying my hands behind my back and asking me to box 15 rounds with Mohammed Ali.

The result is obvious. The system is designed to fail; and the trigger will be pulled. Even in the highly touted Hawaiian system—with employer mandates—coverage has only reached 94 percent.

This trigger is on a gun placed at the head of American business entrepreneurs and Americans themselves.

Mr. President, the Charleston Post and Courier, a local newspaper in South Carolina, recently reported the results of a poll taken by Mason Dixon Political/Media Research, Inc. When asked, "what issue will be most important to you when deciding how to vote in the congressional race?" only 7 percent responded "health care." Twenty-six percent responded that taxes and government spending were most important to them, followed by crime and drugs with 24 percent, education with 14 percent, and employment with 8 percent. Health care was fifth on the list, barely out-polling deficit reduction.

The results of this poll are telling. The American people want health care reform done for the right reasons, not for political gains. Also, based on thousands of handwritten constituent letters and phone calls, I know the people of South Carolina do not want this legislation. The people of my home State do not want bureaucrats in Washington, DC, making decisions on the best way to treat patients in Allendale, Walterboro, Pomaria, Taylors, and the other towns and communities in South Carolina.

It is our responsibility to the American public to ensure that health care reform will be truly beneficial and not harmful to the finest quality health care system in the world. I urge my colleagues to oppose this legislation and work for real health care reform that works and not for another government entitlement program.

Mr. DODD. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. Who yields time?

The floor leader controls 1 minute 5 seconds.

Mr. MOYNIHAN. Mr. President, we yield back the remainder of our time.

The PRESIDING OFFICER. The Republican floor manager has 21 seconds.

Mr. PACKWOOD. I yield back the remainder of my time.

The PRESIDING OFFICER. The majority leader.

UNANIMOUS-CONSENT AGREEMENT

Mr. MITCHELL. Mr. President, there will be no further roll call votes this evening after this vote.

I have discussed the matter with the managers and the distinguished Republican leader and following this vote, I ask unanimous consent that Senator FEINGOLD be recognized to complete his statement.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. MITCHELL. Following Senator FEINGOLD's statement, which he had begun prior to this debate and vote and for which I again thank him for his courtesy in permitting an interruption, there will be 2 hours for debate, which will be equally divided and under the control of Senators MOYNIHAN and PACKWOOD, and after those 2 hours the Senate will remain in session for as long as Senators wish to speak but without any specific division of the time. The managers will take care of that. I put that in the form of a unanimous consent.

The PRESIDING OFFICER. Is there objection?

Mr. BROWN. Mr. President, reserving the right to object, my understanding was I was to have the floor for an opening statement following the Senator from Wisconsin.

Mr. MITCHELL. I made this suggestion as the request of Senator PACKWOOD.

Mr. PACKWOOD. I think we will work this out. We are going back and forth under controlled time, and I will recognize the Senator from Colorado.

The PRESIDING OFFICER. The Senator from New York.

Mr. MOYNIHAN. Mr. President, we will be happy to have the Senator from Colorado as the first speaker following the Senator from Wisconsin.

The PRESIDING OFFICER. There is a unanimous-consent request propounded.

Without objection, it is so ordered.

Mr. MITCHELL. Then, Mr. President, on tomorrow Senator PACKWOOD has indicated to me that he or one of his Republican colleagues will have an amendment to offer, which will be the subject of debate and we hope vote tomorrow, although we are not attempting to reach an agreement on time. Senator PACKWOOD has indicated that he hopes to be able to let us see a copy of that amendment this evening so that we have a chance to review it and be prepared.

With respect to the pending amendment, we provided a copy of that amendment several hours before it was taken up.

I thank colleagues for their cooperation, and I now yield the floor.

VOTE ON AMENDMENT NO. 2561

The PRESIDING OFFICER. Pursuant to the unanimous-consent agreement heretofore entered, all time having been yielded back, the question is on agreeing to the amendment of the Senator from Connecticut. On this question, the yeas and nays have been ordered, and the clerk will call the roll.

The legislative clerk called the roll.

Mr. FORD. I announce that the Senator from Georgia [Mr. NUNN] and the Senator from Tennessee [Mr. SASSER] are necessarily absent.

Mr. SIMPSON. I announce that the Senator from Oregon [Mr. HATFIELD] is necessarily absent.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 55, nays 42, as follows:

[Rollcall Vote No. 288 Leg.]

YEAS—55

Akaka	Feinstein	Mikulski
Baucus	Ford	Mitchell
Biden	Glenn	Moseley-Braun
Bingaman	Graham	Moynihan
Boren	Harkin	Murray
Boxer	Heflin	Pell
Bradley	Hollings	Pryor
Breaux	Inouye	Reid
Bryan	Jeffords	Riegle
Bumpers	Johnston	Robb
Byrd	Kennedy	Rockefeller
Campbell	Kerry	Roth
Conrad	Kohl	Sarbanes
Daschle	Lautenberg	Shelby
DeConcini	Leahy	Simon
Dodd	Levin	Wellstone
Dorgan	Lieberman	Wofford
Exon	Mathews	
Feingold	Metzenbaum	

NAYS—42

Bennett	Durenberger	Mack
Bond	Faircloth	McCain
Brown	Gorton	McConnell
Burns	Gramm	Murkowski
Chafee	Grassley	Nickles
Coats	Gregg	Packwood
Cochran	Hatch	Pressler
Cohen	Helms	Simpson
Coverdell	Hutchison	Smith
Craig	Kassebaum	Specter
D'Amato	Kempthorne	Stevens
Danforth	Kerrey	Thurmond
Dole	Lott	Wallop
Domenici	Lugar	Warner

NOT VOTING—3

Hatfield	Nunn	Sasser

So the amendment (No. 2561) was agreed to.

Mr. MOYNIHAN. Mr. President, I move to reconsider the vote.

Mr. DODD. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

(At the request of Mr. DOLE, the following statement was ordered to be printed at this point in the RECORD:)

• Mr. HATFIELD. Mr. President, today I was necessarily absent for the vote on the Dodd amendment No. 2561. Had I cast my vote, I would have done so in opposition to Senator DODD's amendment because I do not believe the Secretary of Health and Human Services should be designating specific benefits to be provided in health insurance plans. I have always had a strong commitment to preventive efforts, including maternal and child health, and I would hope that any health care reform package we enact will favor these services without the imposition of Federal mandates.•

Several Senators addressed the Chair.

The PRESIDING OFFICER. The Senator from New York.

Mr. MOYNIHAN. Mr. President, before turning to the distinguished Senator from Wisconsin, who so courteously allowed us to interrupt him for this rollcall, may I make the point——

The PRESIDING OFFICER. The Senator will suspend. The Senate is not in order. The Senator from New York claims the floor.

Mr. MOYNIHAN. May I simply make the point, sir, that we have been on this bill for almost 2 weeks and we have not lost an amendment yet. Thank you.

The PRESIDING OFFICER. With that observation noted, under the previous order the Senator from Wisconsin, Senator FEINGOLD, is recognized.

Mr. FEINGOLD. Thank you, Mr. President. I thank you for all your extremely hard work on this piece of legislation.

Mr. President, I had the opportunity on Sunday morning to see some of the talk shows about the Federal Government and national issues, and I happened to watch the McLaughlin Group.

One of the panelists on the McLaughlin Group said something about what was wrong with the Democrats' approach to health care. His conclusion was that we had made two big mistakes. One mistake, he said, was proposing the idea of a health security card for all Americans and waving the card around. He thought that was a terrible mistake strategically.

The other terrible mistake he said was for the President to have held up a pen and say that he would veto legislation that did not provide universal coverage. I was somewhat amused by these remarks because these two symbols—the card and the pen—have been among my favorite aspects of the health care debate. These were symbols of hope, that all Americans at the end of the 103d Congress would have health care guaranteed for them.

So I waited a while before I spoke on the floor. Many Senators have already spoken on health care. Many more will later on. But I wanted to get an initial impression of whether my original view of the importance of this legislation

held up after listening to all the speeches.

I still think the reason for this legislation holds up, and that is the central proposition that every American should be guaranteed health care. The problems with the legislation, the controversy, is not about that principle. There is a tremendous amount of debate about employer mandates and whether we should have a premium tax or the mix of generalists versus specialists, and other very important issues. But it still seems to me that a reasonable centerpiece of the health care debate is whether or not we are going to provide a guarantee of health care for all Americans.

So, Mr. President, I wonder why that issue has seemed to have dropped from view, relatively speaking. To me it is still the most important issue, and that if we do anything with the Mitchell bill, we should strengthen the provisions for universal coverage.

I have felt this way for a while and, naturally, we all campaigned in 1992 on the notion that we would provide health care for all Americans. I think everybody, on both sides of the aisle, probably said something along those lines.

But we did not stop there. We went beyond that into the legislative period, and the words from the famous campaign of the Senator from Pennsylvania have been repeated in many different ways, but they still hold true:

> If criminals have a right to a lawyer, sick people ought to have a right to a doctor.

Those words are, to me, still the basis of a hope and an expectation that we have presented to the American people over the last few years, but in particular in this year. I give credit—tremendous credit—to the President and the First Lady for repeatedly making that known.

The President said in his famous speech on September 22, 1993:

> So I say to you, let us write that new chapter in the American story. Let us guarantee every American comprehensive health benefits that can never be taken away.

I was grateful to have both the President and the First Lady travel to my State of Wisconsin. They did not just visit the big cities. They came to some of our middle-size communities, like Wausau and Janesville, and they repeated over and over again that proposition: That if nothing else, the end of this process will be that every American will have one of these cards to guarantee them health care coverage.

I remember sitting next to my friend, the junior Senator from West Virginia, during the President's State of the Union. Senator ROCKEFELLER and I were chatting now and then during the President's speech, and Senator ROCKEFELLER let me know that he was wondering if the President was going to hold up that pen. He hoped he would, and so did I. We thought it was a critical moment to see whether the President of the United States would say, "If you don't give me universal coverage, I will veto this bill."

So those two symbols gave a lot of people hope—maybe a lot of expectation, but they gave a lot of hope. And to me it is not a case of overpromising. To me this card and this pen are some of the best examples of leadership and strength that the people of this country have come to look for in their President and in their Congress.

The President said in his speech, "I have no special brief for any specific approach, even in our own bill, except this. If you send me legislation that does not guarantee every American private health insurance that can never be taken away, you will force me to take this pen, veto the legislation, and we will come right back here and start all over again."

So, Mr. President, I think the card and the pen are very powerful symbols. One expresses the promise of guaranteed health care for every American that could never be taken away. The other gives meaning and force to that promise. And I can tell you, having been all over Wisconsin holding town meetings and listening sessions, the card and the pen meant a lot to the people of the State of Wisconsin, and they expect us to act on it.

We have not seen much of those symbols lately. For many, the comfort and the reward of the status quo have been a little too tempting. The very interests that have fattened themselves on the inequities and inefficiencies of the current system have understandably fought to keep those defects and weaknesses in place.

To date, I am sorry to say, those interests have been successful in obscuring the debate, and many who have aligned themselves with these interests have done a tremendous job, a masterful job of misstating our health care problems. The other side has a tremendous skill. The other side knows how to keep it simple. They weigh a bill. They say it is Big Government. They bring out a chart that looks complex but is actually less complicated than the current system. They are darned good at that.

We need to get good at it, too. We need to talk about the simple message that this card and this pen are about a commitment that this side has to every American that the other side does not.

I remember well last year during the deficit reduction debate there was another symbol. In fact, some Boy Scouts handed me this symbol. It was a false symbol but it had been mass produced. It said, "No middle-class tax increase." Some of the folks on the other side had everybody in this country including Boy Scouts in Ripon, WI, believing that everybody's income taxes were going to go up under the President's deficit reduction bill.

It was not true. And the statistics show that only 1 percent of the people in this country had their income tax rates increase. But the symbolism worked. That little card misrepresented the deficit reduction bill and it took us months to undo, the consequence of people being misinformed of what the bill really did.

Mr. President, we need to return to talking about guaranteeing every American this health security card.

I am struck by the sort of having-your-cake-and-eat-it-too attitude that I heard out in the Chamber during the last 10 days. Just about everybody in this body says they are for universal coverage, but they say it is a question of how and when you get there, and whether or not somebody is willing to vote for the tough law that is necessary to make that kind of health care coverage possible.

Now, of course, there are some people who take the view that universal coverage is a bad concept. Some say it is an example of socialism—it is socialism to talk about letting every American have health care cards. Others pay lip service to the concept of universal coverage but say what we really need is universal access. But universal access is different than universal coverage. Universal access means if you have the dough, if you have the money to pay for it, you get coverage. It does not guarantee coverage.

Perhaps this problem of terminology was best shown yesterday when I had the chance to hear the junior Senator from Texas indicate that she believes that universal coverage is a noble goal and one that she said she shared. My question for you, Mr. President, and my colleagues is, how did we get from a guarantee of health care coverage and a right of health care coverage to the idea that it is simply a noble goal, like eliminating poverty or eliminating all environmental pollution.

For me, universal coverage has long been the core issue of health care. That does not mean there are not other terribly important issues. One is cost containment, the fact that this system, a combination of private and public health care, is going to go over $1 trillion this year for the first time; another is, the issue of comprehensive benefits including mental health benefits and it is extremely central to this debate; the issue of home and community-based long-term care for the elderly and people with disabilities is the issue I have spent the most time on and talked to most every Member of the Senate about.

All of these are important and all of these should be addressed, but all of these are part of a larger reform which has its first principle in this, universal coverage. Sometimes I fear that there is not much talk about universal coverage or guaranteeing health care and that all these other issues are raised so

that that issue does not have to be discussed. It is too central. It is too obvious. It is too simple that this country has come too far to still be one of the few industrialized countries in the world that does not guarantee health care.

For me, this goes back all the way to 1972. I was 19 years old at the time. I bought and read a book by the senior Senator from Massachusetts. It was called, "In Critical Condition." It was one of the first and most important articulations on the notion that health care should be a right for all Americans. And I admit I was young at the time. I also believed in 1970 that when we started Earth Day, we would not have much of a problem with environmental pollution some 20 years later, but we still do. But that was youthful optimism, and I really believed that when Senator KENNEDY's book came out it would not be long before we could say that health care is a right of all Americans.

I am embarrassed that this country has not achieved that goal. I am embarrassed that the most powerful and rich country in the world still cannot say that each and every person in this country has a right to coverage. I am very proud of my country, but I am embarrassed by that.

This has been an article of faith for me and has been throughout the years until 1988 when I held hearings in Wisconsin on long-term care. And it was all supposed to be about home and community-based care. But it was interesting; some people came to the hearing, some representing labor, some representing health care groups, and they said, "State Senator Feingold, would it be OK if we talked a little bit about health care in general?" They taught me something I did not know. I did not know that 500,000 people in Wisconsin were uncovered. I knew that some were, but I was astonished to know that over 10 percent of the people in the State of Wisconsin did not have that coverage. Growing up in Janeseville, WI, I believed and I assumed that all kids had health care coverage, whether they were rich or poor. And what really got me was learning at these hearings in 1988 that the only other industrialized country in the world that did not have that commitment to universal coverage was South Africa. Why the United States and South Africa? Why our country?

How can it be that we have the best health care system in the world, as the other side is so fond of saying, if 37 million Americans are not covered?

So that is why this card and this pen are so important. They are the key to showing all Americans that we are committed to each and every one of them. As the President said on November 20, 1993, under this legislation every citizen and legal resident will receive a health security card that guarantees the comprehensive benefit package.

So the question before us, that I think ranks above all other questions, is, do all Americans have a right to one of these cards? And will the President use the pen to enforce it? I certainly hope so.

But I have been a little disappointed lately. I made note of it at the time to read a headline in the Washington Post: "Clinton Backs 95 Percent for Health Care." To me, 95 percent is not 100 percent. That is a disappointment. The problem with the analysis of the 95 percent figure is that it involves a confusion, a confusion between the practical problem of making sure that everybody uses their right to coverage, and the legal notion that everyone should have a right to health care. In other words, you can have universal coverage for all Americans, but only 95 percent of the people may actually make use of that protection.

I am not saying that this is a constitutional right. Perhaps you could make that argument. The Founding Fathers talked about life, liberty, and the pursuit of happiness. That is not what we are talking about here. What we are talking about here is whether we are going to provide a statutory right, a public law that creates a statutory right, for every American to have health care. That is not in the Constitution, but the act of the Congress and the President.

Part of the problem with the sort of have-your-cake-and-eat-it-too added to universal coverage is that, if you believe that universal coverage for all Americans is impossible, you get statements like, "It is a noble goal." And many Senators come out and say it just cannot be done, that there is no such thing as universal coverage. That is not the case. It is based on a misunderstanding. I hope that misunderstanding is accidental.

The junior Senator from Texas said yesterday on the floor of the Senate that Canada did not have a guaranteed right to universal coverage. I have before me the provisions of the Canadian law.

Mr. President, at this point let me say that I could not be more delighted with the outcome on the amendment just preceding. I congratulate the Senator from Connecticut.

Mr. MOYNIHAN. Mr. President, may we have order.

The PRESIDING OFFICER. The Senate is not in order. Senators are encouraged to carry their conversations off the floor.

The Senator from Wisconsin, Mr. FEINGOLD, retains the floor.

Mr. FEINGOLD. Mr. President, I again thank the Chair and would like to say again that amendment was an important moment in this health care debate. It took us a long time to get to it. The other side did try seriously to defeat it, but they were not able to because the force behind this effort to provide health care to all Americans, including children, will prevail. In that spirit I would like to take a moment to cite a statement of the senior Senator from Massachusetts, from 1972, from his book, "In Critical Condition."

Senator KENNEDY said:

> I believe good health care should be a right for all Americans. Health is so basic to a man's ability to bring to fruition his opportunities as an American, that each of us should guarantee the best possible health care to every American at a cost he can afford. Health care is not a luxury or an optional service we can do without.

Senator KENNEDY said:

> Every child who is retarded or whose arms or legs remain twisted because his parents could not get care, every family that faces financial disaster because of the cost of illness or is broken by unnecessary suffering or death, is kept from fulfilling the right to life, liberty, and the pursuit of happiness that we cherish in America.

Those words are 22 years old. But today, a few minutes ago, the U.S. Senate began the long march to making sure that dream can become a reality for all Americans.

Mr. President, let me reiterate that when you say health care is a right for all Americans, or that we guarantee health care for all Americans, you are not necessarily saying it is a constitutional right. It may be. You could argue that. But what we are about here in this effort, in this Congress, is to try to create a law, a national law, a Federal law, a statutory right for all Americans to basic health care benefits.

But again, there are those who want to have their cake and eat it too on this issue. They want to say universal coverage is a noble goal but that it cannot be done; there is no such thing as universal coverage in any country or in any place. But that is based on a misunderstanding of what the notion of guaranteeing universal coverage is all about. I hope it is an accidental misunderstanding. Too often during this debate I fear it has become a convenient misunderstanding; an effort to confuse the American people and make them think that it is literally impossible to guarantee every American the right to health care. That is not the case.

The junior Senator from Texas said yesterday, "Look at Canada. They do not have universal health care in Canada."

That is incorrect. In Canada universal coverage is not a goal. It is not a hope. It is a right.

All residents of a province must be entitled to insured health services.

That is what I mean by a statutory right. As a matter of law in Canada, every Canadian has a right to health care. I know of no exceptions.

The Senator from Idaho yesterday tried to point out that in Hawaii not everyone is covered, even though they, apparently, have an excellent system

based on an employer mandate. It is the case that a certain small percentage of the people of Hawaii are not covered. But that is because they have not chosen to make health care a right for all Hawaiians. There are statutory exceptions—apparently for State employees and for certain part-time employees. So they have not made that commitment, although they have made a tremendous effort in the absence of it.

Others have said universal health care coverage is impossible. They say look at the Social Security system. We have had it for many, many years but not everyone is part of Social Security. Mr. President, that is because we have chosen to exempt as a matter of law, as a matter of statute, certain people from the Social Security system. We have never said in this country that Social Security is a right of every senior citizen or every individual.

The PRESIDENT pro tempore. Will the Senator suspend? The Senate will be in order.

The Senator will proceed.

Mr. FEINGOLD. I thank the Chair.

In all candor, Mr. President, colleagues, I have to say that even under Senator MITCHELL's bill, the statement by some that we can never get to 100 percent and therefore we will go to 95 percent does not really add up. If that is the case, why is there a provision in the Mitchell bill saying that if we have reached 95 percent by the year 2000, that a congressional commission will be formed in order to make recommendations so we can go that final mile, so we can get the next 5 percent, the 100 percent coverage? I think a lot of this confusion again comes from not understanding the distinction between the practical problem of actually delivering health care to all Americans and the existence of a statutory right. The difference is between coverage and usage. Everyone can and should be covered by law. But that does not mean that everyone will use health care services. That is a practical problem. Maybe we can compare it to the right to vote. All qualified electors in this country have the right to vote.

Mr. President, we all know painfully that not everyone exercises that right to vote. We have one of the worst records in the world in terms of the exercise of that right. But that does not make it any less the right. Every person 18 years old who is qualified and is not disqualified for reasons of having committed a felony has a right to vote. That is the difference between a right and the effective problems of trying to get everybody out to vote. So too is there a difference between coverage and actual usage.

I believed, and I am not ashamed to say anywhere, that I think in the United States, health care should be available on demand for a person who seeks it. No one should be able to be turned away. Yes, Mr. President, I say it is a guarantee that should be given to all Americans, and I use that word in a positive sense.

I will go further. It is an entitlement. I will stand here on the floor of the U.S. Senate and say health care should be an entitlement. Well, you are not supposed to use that word these days. It is a bad word, and I agree we need entitlement reform in a lot of areas. There are programs that need to be looked at. But I am not afraid to stand here on the floor of the Senate and say when it comes to the notion that every American should be guaranteed basic health care coverage, that is an entitlement that stems from being an American, and the fact that we have not made it an entitlement for every American is a shame on this country, not something to be proud of.

So, Mr. President, you cannot force someone to go and get a checkup. We are not going to put a gun to their head and say, "If you don't get a checkup, you're in violation of the law."

But if someone wants a checkup, if any American in this country feels they need a physical, they should have a right to do it, they should be entitled to it as a result of their being Americans citizens. So the key distinction here is between coverage, 100 percent coverage, and a 100-percent right to coverage.

Let us try to break it down briefly. It is very hard to examine all the provisions of the bills that have been introduced from the beginning, from the President's bill all the way through. And, yes, some of them are 1,500 pages and some are 700 pages.

But on this issue of whether health care is established as a right, that is basically a yes or no answer for each of the plans. Let me run through them.

Under the President's plan, the answer is yes, health care is a right.

Under Senator WELLSTONE's excellent plan for a single-payer system, health care is guaranteed and is a right.

Under the Labor Committee bill, health care is guaranteed for all Americans; it is universal coverage.

Under the Finance bill, that is not the case.

Under Senator GRAMM's bill, the Senator from Texas, the answer is no, it does not provide for universal coverage.

Under the bill of the Senator from Oklahoma, Senator NICKLES' bill, the answer is no, it does not include universal coverage.

One of the members of the Republican caucus, Senator CHAFEE, has a bill, frankly, which does provide universal coverage.

The bill from the House, from the other body, by one of the Representatives from Tennessee is a no. That bill, the so-called Cooper bill, does not provide universal coverage.

The Mitchell bill is not entirely clear. There are two scenarios under the Mitchell bill where universal coverage could occur, where that right would be guaranteed. One is if all the States did not achieve 95 percent coverage by the year 2000, then the mechanisms would kick in that would, in effect, require universal coverage. The other scenario is if we do not achieve 100 percent coverage by the year 2000, then a commission is supposed to make recommendations to Congress that would provide for the type of legislation and rules that would get us to complete coverage.

I think this aspect of the Mitchell bill needs to be strengthened, but at least there are provisions in that bill that could move us in that direction if it worked out right.

Finally, let me say the bill proposed by the majority leader in the other body does provide universal coverage.

So I say to my colleagues and anybody who is watching, this is not all that complicated, this piece of the issue, this central issue. Some of the bills make the commitment to every American and some do not, and to me there is no more important issue than whether that is provided.

To me, giving health care coverage to all Americans is the touchstone of this entire issue, regardless of how we implement it.

Mr. President, we supporters of universal coverage run into a little bit of a problem if we start talking about trying to get close to 100 percent coverage, if we start playing the numbers game. One problem that the President and the majority leader both identified very clearly is that if you do not cover all Americans, there is cost shifting involved. Somehow the system works in a way that the costs get shifted and those who are not covered or choose not to be covered actually cause those who are covered to pay more.

Insurance reforms, such as banning restrictions based on preexisting conditions and guaranteed portability, extend coverage to the sick and other high users of the health care system. What happens, Mr. President, is the newly insured sick drive up the premiums for the currently insured and this, in turn, causes higher premiums because some healthy individuals who are currently part of the health care plan of the insurance company drop coverage. They decide to go without that coverage because it is getting too expensive.

This shrinks the insurance pool. Because the sick and the high users of health care remain in the pool, the average costs for the pool increases and it drives up the premiums again. Higher premiums again cause more healthy individuals and firms to drop coverage, and it keeps going. The costs of the system go up rather than down if you do not have complete coverage.

There is also a problem with saying that we are going to try, as the Mitchell bill suggests, to get to 95 percent.

That is sort of the new goal that was identified. The problem for me is that in Wisconsin, a pretty good-sized State—not one of the biggest, but I think 16th or 17th in the country, about 5 million people—if we only get to 95 percent, 250,000 people will not be covered, a quarter million people in the State of Wisconsin alone will not have health care coverage.

Finally, what troubles me about this numbers game, saying we will never get higher than 95, let us go for it and try for 96, 97, or 92, is that it leads us down the slippery slope that the Republican leader wants us to go down. Obviously, he knows what he is doing. He gets up on the floor and says during his opening statement, which I had a chance to witness here in the Chamber, "What is all the argument about?" He thinks his bill will get to 92 percent, we will get to 95, so what is all the hullabaloo about 2 or 3 percent?

Two or 3 percent does not sound like very much. But 2 or 3 percent is a lot. Fifty-eight million Americans were uninsured for some part of last year. But what is the difference between 92 and 95 percent? Three percent of the Republican leader's State of Kansas is 75,000 people. Three percent of Wisconsin is 150,000 people. Three percent of the United States of America is 7.5 million people. That is not a little number, that is the combined population of Kansas and Wisconsin. Ninety-five percent is not universal.

The difference between 95 percent and 100 percent is 5 percent. Five percent of Kansas is 125,000 people. As I have said, 5 percent of Wisconsin is about a quarter million people, about 250,000. Five percent of the United States of America's population is 12.5 million people, five times the size of Kansas, 2½ times the size of Wisconsin, and it equals the combined populations of 13 States and the District of Columbia: DC, Wyoming, Vermont, Oklahoma, Mississippi, New Mexico, Delaware, Nevada, Alaska, Montana, Rhode Island, Idaho, Nebraska, and Utah. That is what the Republican leader says is only a little 2- or 3-percent difference; "What is all the arguing about?"

Well, that is very significant. We cannot allow the moral force that we have on this issue that Americans have a right to coverage to be trivialized by the use of percentages.

We have to confront it head on. We have to confront the fact that we are talking here about 12 to 15 to 16 million Americans, depending on which bill you are talking about.

To put it in more human terms, I have to ask, who are these people? Who are these 12.5 million people who will not have health care coverage? And what am I supposed to tell them after we get this done? What am I supposed to tell them? Am I supposed to say, "I am sorry; you don't get one of these cards. Better luck next time, 50 years from now, when we do health care again."

Am I supposed to tell them that the homeless people will have the coverage—they will under any one of these plans—but that the working poor will not? Am I to tell them that somebody who is on welfare gets this card but they do not? Am I to tell them that all the Members of the Senate will have the coverage but they will not?

My good colleagues from Minnesota and Illinois, Senators WELLSTONE and SIMON, the other day put on a little performance where they picked out 5 Ping-Pong balls out of a group of 100 and said, "I wonder which 5 Senators will not get health care coverage if 5 percent of the American people are not going to get health care coverage."

We know very well that no Member of this body and no Member of the House will have that consequence. So the question really becomes who are these 12.5 million Americans that are not in on the deal, that are not going to get one of these cards?

Recently, in the Washington Post, there was an article making light of the fact that the Members of the Senate come out here and give human examples of this health care issue almost as if to say when are they going to stop telling about their mom or dad. But that is the only way it can be done, by putting it in human terms. So, forgive me, but I think it is appropriate to talk about the fact that I believe these 12.5 million Americans are, by and large, lower and lower middle-income people, a lot of them women, who work for small businesses, who make, let us say, $15,000, $20,000 a year. My analysis is that this is the largest share of the people who will not get health care under this bill—not the very poor; they are covered; they are covered now, but the working poor.

I encountered two examples of this back in Wisconsin in recent months. I was sitting on the airplane going back to Wisconsin on our own Wisconsin airline, Midwest Express, and I started talking to a young woman who told me that she was on her way to law school. She had been divorced. She has two children. She told me during the course of our conversation that she had had cancer, but, fortunately, she has had a clean bill of health for 5 or 6 years.

So I asked her, "Do you think you will be getting health care coverage?"

Answer: "No." In part, because of the preexisting condition issue. But even if we eliminate barring coverage for existing conditions she still may not be covered. That is because she did not have the economic wherewithal to buy insurance. She has some child support. But she is trying to go to school. She is trying to get that law degree. And what this does, because she makes too much for a subsidy but not enough to pay for the health care, is leave her out in the cold. This person who has had some rough breaks along the way already is trying to make something of herself, and in this country we cannot deliver her this health care.

One other example. I was in a beautiful place in the State of Wisconsin earlier this year, Buffalo County, WI, on the Mississippi River. It has had the great experience of having bald eagles restored there that were once gone. I went there to hold a town meeting. It was going fine, and near the end of the town meeting, one lady got up and said that her job was to be an elderly benefit specialist which is a program in Wisconsin where people help older people try to figure out their tax forms and health care benefits. It is an excellent program and I had the good fortune to help create it in the State of Wisconsin.

She was telling me about the program. But all of a sudden she sort of broke down in tears. She told me that she was probably going to have to leave that job where she tried to help other people understand the health care system and she was going to have to become a receptionist at another place of work because she did not have health care. Here is a person serving the health care system who is going to have to leave that system and will not be covered under many scenarios under this plan.

What are we to say to these people? "You are not part of the American dream." Are we supposed to say, "Sorry about that." Are we supposed to say, "Sorry about the lack of coverage for you and your children, too." I do not look forward to the prospect of doing that.

It leads me to yet another problem, sort of the flip side of the issue. I have heard the Republican leader and others all across the country say, hey, this is only an issue for 15 percent of the people of the country or 38 million Americans. Why not just take care of that group. Why not just give them health insurance.

That sounds pretty good. It is really simple, just like holding up a bill and weighing it. Really simple. But the problem is it is so simple that it oversimplifies the issue so as to make it not accurate. The health care crisis is not about some fixed group of people. That 15 percent or that 38 million is just a snapshot. It is the number of people at any one time that are uncovered, and it is constantly changing. It would be like trying to remove a flaw from a movie by correcting only one frame. That particular frame might look better, but the rest of the movie will still be flawed.

As I have said before, during any particular year, we can expect that 58 million Americans will be without any health insurance for part of that year. And the coverage appears to be slipping.

The First Lady, in continuing her hard and courageous fight for this legislation, announced today that since we started working on this bill, 500,000 more Americans have had their coverage dropped. And those businesses that continue to provide coverage for their employees are subsidizing more and more of their competitors.

Beyond that, the health care crisis is also about controlling costs. And here again it is well established that the only way you can control costs is through universal coverage. As I have said, another tempting diversion is the refrain that we should, of course, strive for universal coverage as a goal but that 95 percent or 92 percent or 90 percent is acceptable. Again, it sounds reasonable on its face. Let us do what we can for the President may be the notion. After all, 95 percent or 92 percent or even 90 percent coverage is better than what we have now.

But this goes to the heart of the issue, both in the general perception of our health care problem and the underlying philosophy of reform.

First, there can be no effective cost containment without universal coverage. So the failure to guarantee health care coverage that can never be taken away means that costs will go up. And as costs go up, certainly coverage will go down. But, Mr. President—and this is really the central point—even if costs could be contained without universal coverage, the failure to guarantee health care coverage that can never be taken away means that health care coverage can be taken away. As long as there is any gap in coverage, everyone, every American, is at risk.

Let me move to the last part of my opening statement by just presenting a couple of analogies to illustrate this. A couple of them are a little more lighthearted. The first one is appropriate for Wisconsin. It has to do with mosquitoes.

In Wisconsin, in August, there is nothing more compelling than the notion of mosquitoes. Some have even suggested that, given the size of mosquitoes in Wisconsin at this time of year, instead of the robin, the mosquito should be our State bird. The analogy is to good mosquito netting. Guaranteed coverage is like good mosquito netting. Anything less than 100 percent is not much good. It does not matter if the hole is an 8 percent hole or 10 percent hole. Unless the mosquito net gives you 100 percent coverage, it is not very pleasant camping in Wisconsin at night.

Let me try a different analogy for our coastal States. It is like a lifeboat in the middle of the ocean. If there is a hole in the bottom, it does not much matter if it is a 7-inch hole or 10-inch hole. Unless you completely plug up the hole to get 100 percent coverage, you are going to get pretty wet.

The final analogy is that health care coverage is kind of like a chain, Mr. President. It does not matter much if 10 percent of the links are weak or only 5 percent are weak. Unless 100 percent of the links are strong, the chain will break.

Mr. President, in this case, it is a human chain of Americans who should all be linked together in one respect, that each and every one of them knows, as a right of their birth as an American citizen, that they have that coverage.

Mr. President, let me come to the final part of my statement by pointing out the simple fact that there are two major bills being discussed out here now: The bill of the Republican leader and the bill of the majority leader.

There is no comparison between the two with regard to the issue of universal coverage. The bill of the Republican leader leaves such a gaping hole that there is no chance of achieving universal coverage.

According to the Lewin-VHI analysis of the Dole proposal, three out of the four uninsured Americans would be left without coverage in the year 2000. That same analysis of the Dole bill found that 6 million children will still be uninsured at the end of the decade. Under the Dole-Packwood bill, Congress is not even required to consider recommendations for achieving the goal of universal coverage, as does the bill of the majority leader.

As I have said before, I think the universal coverage provisions of the majority leader's bill need to be improved, but at least there is a serious effort there to create mechanisms that can lead to universal coverage. In this respect, there simply is no comparison between the Mitchell bill and the Dole bill. The Mitchell bill has its goal of achieving universal coverage for all Americans.

To conclude, let me just say I again want to return to these two symbols, a card that every American should have and the pen that the President should be ready to use if this bill does not provide universal coverage.

I saw a cartoon in one of our major newspapers in Wisconsin of a couple of days ago. It is lighthearted, but sort of lets us know how far away we have come from this simple symbol of a universal health care card. What it shows is President Clinton on the ground holding a crime bill, and he is pretty battered. He has been treated pretty harshly by a couple of elephants. There is even a donkey behind him with sunglasses. One of the elephants says to the other, "What did you find?" After he looked through the President's wallet, the other elephant says, "No cash, just one of those cards supposed to guarantee health care coverage."

I am concerned that is all that is going to become of this card, that it will end up being a subject of humor for political cartoons.

It is sobering for me to think that 22 years ago I read the book by the senior Senator from Massachusetts. But I think he was right then, and I think he is right now. This country has to provide universal coverage to all Americans.

He said in his conclusion:

> We have a choice of conscience to make in America. It is a choice of whether we will assure each other and all Americans good health care at a cost they can afford. The pages of this book are filled with the tragic stories of the people who have been hurt because we do not make this assurance. We can put an end to such stories, and I believe we should. I urge Americans to search their hearts to choose and to make their choice known. To take so major a step the government needs your support.

Mr. President, I say today, some 22 years later, we need the support of this body. We need the support of the U.S. Senate to finally guarantee to all Americans health care that can never be taken away.

Mr. President, there ought to be a law. Mr. President, there ought to be a law that guarantees every American—every American—a right to health care coverage before the end of the 103d Congress.

Mr. President, I yield the floor.

Mr. MITCHELL addressed the Chair.

The PRESIDENT pro tempore. The majority leader.

Mr. MITCHELL. Mr. President, I want to thank my colleague from Colorado for permitting me to proceed next. I do not have a lengthy speech, but I do have a few comments I would like to make. I know he has been waiting for some time. I am grateful for his courtesy, as I am of the earlier courtesy of the Senator from Wisconsin for permitting his remarks to be interrupted.

Mr. President, during the course of this debate so far, my bill has been the subject of many misrepresentations, distortions, and some outright untruths.

There have been so many that I have not been able to respond to all of them. But I want now to respond to statements made today which were categorically untrue for which I believe a response is necessary.

It is clear that the tactic of the opponents of this legislation, at least many of them, is to confuse and frighten the American people, and they are attempting to do so by making statements about my bill that are untrue.

This is a document distributed today by several Republican colleagues criticizing the legislation under the headline "Clinton-Mitchell denies consumer choice." It then states, "You can keep your own plan unless your plan is less generous; you can keep your own plan unless your plan is more generous." And the text that follows is intended to clearly convey to the American people that there can be no plan other than the standard benefits plan contained in my legislation. That is untrue. I repeat. That is untrue.

Mr. President, my bill, like many of the bills introduced by Republican Senators as well as Democratic Senators, provides for a standard health benefits package, the purpose of which is to provide uniform coverage and to make it easier for consumers to choose between competing health plans based upon price and quality, as opposed to different types of options.

The bill requires employers to make three types of delivery plans available to each consumer so that, although the benefits package would be the same. There would be a traditional fee-for-service plan, a health maintenance organization type plan, and other plans commonly referred to as "preferred providers." And the individual would choose among the three plans. But—and this is an important but—under my bill, individuals can purchase supplemental benefit coverage above the basic benefits plan if they choose. If they want to have additional benefits or different types, or different types of cost-sharing protection, they are free to do so. So the suggestion that no one could purchase better coverage than the basic benefits plan is incorrect.

Second, my bill also includes an alternative standard health benefits package which would cost less because, although the coverage would be the same, the deductibles and copayments to be paid by the consumer would be higher.

So an individual, therefore, could choose an alternative benefits package with lesser coverage in the sense that the deductibles and copayments would be higher. So the suggestion that a person could not buy anything less than the benefits package is also untrue.

I want to repeat that so there can be no misunderstanding. Every person would be offered three types of delivery plans of the standard benefits package. But any person could choose either to supplement that with additional benefits coverage if he or she wishes to do so, or an alternative standard package which would cost less because the deductible to be paid by the individual or the copayment to be paid by the individual would be higher than in the standard benefits package.

On this question of choice, that it denies consumer choice, the fact is that the legislation would increase choice, and it would increase it in the following way: Right now, most Americans receive their health insurance through employment. A person gets a job, the employer makes health insurance available in some form or another, and the employee is, therefore, covered. But for the overwhelming majority of Americans, the only choice of plan is to accept or reject a plan which the employer negotiates with the insurance company. So the employer meets with the insurance company, agrees on a plan, then makes it available to employees, and the employee must then choose to participate in that plan or not. One plan.

Under this legislation, employers would be required to make available to employees three different plans. Although the benefits package would be the same, the method of delivery would be different and, therefore, the price and cost would be different. And so the employee could choose, for example, a traditional fee-for-service plan, in which the employee retains the right to choose any doctor he or she wishes to visit, or the employee could choose an HMO-type plan in which the employee agrees to be treated by the organization and the physicians who are in the employ of the organization. The individual then gets the choice, and each individual will be able to make it based upon price and what he or she sees as important to them.

I repeat and emphasize that if that individual does not think that the coverage provided in the standard of benefits package is broad enough, he or she can go out and buy supplemental benefits. And if he thinks that is a good plan, but he cannot afford to pay that premium and is willing to take a chance of having to pay a higher deductible, he can choose the alternative standard benefits package and, accordingly, pay less but be subject to higher deductibles and copayments if the person becomes ill.

So, Mr. President, I hope very much that we can have a good debate on this bill. But I hope it will also be accurate.

Finally, I will conclude with one further point, and that is this: Over and over and over again, the statement has been made that this bill provides for a "Government-run" health insurance system. That has been said dozens, if not hundreds, of times. A "Government-run health insurance system." I make two points on that. First, the bill does not so provide. It does not provide for a Government-run health insurance system. It provides for a voluntary system in which Americans would purchase private health insurance. Indeed, in that respect, my bill does the opposite of what has been suggested, because right now, there are 25 million Americans who receive coverage under Medicaid, which is a Government program. And, under my bill, that portion of Medicaid would be abolished, and those individuals would be encouraged and assisted in the purchase of private health insurance. So they would receive health insurance coverage in the private market on the same basis that other Americans are now receiving. So it actually reduces one of the largest Government programs and has those people enter into the private insurance market. And so I hope that people will look beyond the rhetoric.

I know the mood in our country today is that a popular way to attack anything is to say it is "Government-run" and to suggest somehow that it is therefore inefficient. Of course, our colleagues who make these statements all support the Veterans Administration health care system. It is the largest health care delivery system in the country, and it is a Government-run system. Not only do they support it, they go around to veterans parades and veterans facilities and veterans meetings, and they tell the veterans how they are going to protect their health care system, and they run television ads when they are up for reelection saying how they are going to protect the Veterans' Administration health care system. They do not go around to their States and say, "I am against Government-run systems, and the Veterans Administration system is a Government-run system, so we ought to abolish it." They say just the opposite.

The same is true of Medicare. Medicare is a Government-run system. Not one of our colleagues who stood here and said, "I am against Government-run health programs" goes back home and says to the elderly citizens, "I am against Government-run health insurance systems, so I favor abolishing Medicare." They say just the opposite. They go to the senior citizens homes and coffees and stand up and say to our elderly citizens, "I am going to protect your Medicare system," and they run television ads promising to protect the Medicare system, a Government-run health insurance system.

Of course, the largest Government-run program in the country is Social Security. It is a Government-run program, and it includes health insurance with Medicare, Part A. Not one of our colleagues goes back to their States and goes around to senior citizens centers and says to those people there, "I am against Government-run programs, so I am going to vote to abolish Social Security." They say and do just the opposite there as well. They go and they say to the senior citizens, "I am going to protect Social Security," and they run television ads telling people how they are going to protect Social Security.

So while they stand here and say they are against "Government-run programs," when they go back home to their constituents, they spend a lot of time and effort and money telling their constituents how they are going to protect those very Government health insurance programs. I hope people will keep that in mind as they listen to this debate.

I want to say that Senator MOYNIHAN happens to be sitting here, and we had a ceremony at the White House yesterday in which the President signed into law the legislation to make Social Security an independent agency. Senator MOYNIHAN is the author of that bill and the person who has done more in our Nation to protect and enhance and improve Social Security than any other. This legislation is the latest in a series

of achievements in that regard. I think, better than any of us, Senator MOYNIHAN understands the importance of Social Security to our Nation.

I conclude by saying that the arguments made today against this legislation are almost word for word the arguments made against Social Security, and almost word for word the arguments made against Medicare—almost word for word.

Mr. President, those items did not prevail then, and I hope they will not prevail now. I thank Senator BROWN again for his courtesy. I think I went on longer than I had anticipated. I apologize, and I thank him for his courtesy.

Mr. BROWN addressed the Chair.

Mr. PACKWOOD. Mr. President, out of curiosity, how much time is on our side?

The PRESIDENT pro tempore. The Senator from Oregon has 60 minutes under his control.

Mr. PACKWOOD. I yield such time as the Senator from Colorado wishes.

The PRESIDING OFFICER. The Senator from Colorado [Mr. BROWN] is recognized for such a time as he may consume, within the 1 hour that is under the control of Mr. PACKWOOD.

TRIBUTE TO ABNER MIKVA

Mr. BROWN. Mr. President, I rise to pay tribute to a recent appointee of the administration. Last week, Abner Mikva was sworn in as counsel to the President. He takes the place of Mr. Cutler, who had held that job temporarily.

Mr. President, I want to comment on this because I know Abner Mikva, and while we do not share the same political party and while we do not share the same political philosophy, I know him to be a person of exceptional integrity, of great intelligence, and of great character.

He was a Phi Beta Kappa, Order of the Coif, distinguished scholar, cum laude graduate of the University of Chicago Law School, Phi Beta Kappa graduate of the University of Wisconsin. He has had an exceptional career of public service, including 10 years in the Illinois State Legislature, five terms in the U.S. House of Representatives, and serving until recently as the chief judge on the D.C. Circuit Court of Appeals, where he had served from 1979 forward.

Mr. President, I pay tribute to him because he is an individual who not only has achieved great things in his lifetime, but he is an individual who clearly indicates by his conduct and his demeanor and manner that he places truth and integrity above all other considerations in public discourse.

He is exactly the right person at the right time for the White House. I do believe this, that some of the problems that are surfacing about Whitewater, or at least the way it has been looked at and investigated, would not have occurred if Abner Mikva had been there. I think he will make a difference.

Ultimately, he will do great service for the President of the United States, and I believe he will do great service for the country as well.

It is this kind of exceptional integrity and commitment that this Nation so urgently needs, and it is a great privilege for me to commend the President for this appointment that I think will serve us all well.

HEALTH SECURITY ACT

The Senate continued with the consideration of the bill.

Mr. BROWN. Mr. President, the discussion on the health care bill has involved a large number of terms, and it must be confusing to people. But I want to cover just a couple of them at the outset, because I think they go to the very heart of the matter.

We have heard discussed repeatedly that we need to have universal health care coverage, and the suggestion is that without universal health care coverage, people will go without health care. Everyone listening should know that is not accurate. Health care coverage is dramatically and significantly different than health care. How so? You may not have health care coverage in the form of an insurance policy, but you do qualify for health care treatment at a low-income health care clinic. Those clinics are spread across the Nation.

When people do not have an insurance policy, it does not mean they suffer from a lack of health care. It means they do not have that mechanism for paying for it. You may not have an insurance policy, but you can go to an emergency room in a hospital and receive the treatment. If you are unable to pay for it, ultimately that debt will simply be written off. Again, you do not have an insurance policy but you can receive health care treatment.

Someone asked me why in the world are we debating and talking about health insurance when what we ought to be concerned about is health care.

Mr. President, I do not know if there is an easy answer to that. Some of the folks who brought this bill to the floor are interested in Government control of health care because they feel it will improve it. That by forcing people to have health insurance, the vision of Government control is accommodated, the need to control health care met. The focus on insurance is merely a device, not to provide health care, but to control this portion of our economy. That is what this is all about, a sincere and honest belief that this country would have better health care if indeed we had more Government control.

I thought tonight it might be worthwhile to spend a few minutes and simply take a look at what our experience has been in that area. The view is widely held that more Government control, dominance, and regulation of health care and its cost can improve the situation. It is clear that many of the legislators who favor the bill before us sincerely and deeply believe this.

Mr. President, we should not have amnesia. We ought to be willing to at least look at the facts and face them honestly and see whether or not that thesis holds water.

One of the major moves after the World War occurred in 1946 in the area of health care. It was the Hill-Burton bill. The Hill-Burton bill was designed to provide grants for construction and modernizing health care facilities. Many of the grants ran from one-third to two-thirds of the entire cost of the project. The thesis was if you have Federal Government assistance, then you would be able to provide additional health care through those facilities. It was a very large program, and between 1946 and 1974, $4 billion was spent in it.

Now, did it solve the problems of health care? Well, read what the Democratic-controlled committee said about it in 1974. This is the House Interstate and Foreign Commerce Committee. The Democrat-controlled committee found that after $4 billion of public funds had been spent on Hill-Burton, about 60,000 unnecessary hospital beds had been built, costing as much as $20,000 a year in overhead.

Mr. President, this is what happened with Government intervention that was meant to solve the problem. The Government came up with money to hand out to solve the problem and what they did is by their own evaluation was build 60,000 unnecessary hospital beds costing in overhead alone, not the costs of the bed, in overhead alone, up to $20,000 a year. The overall cost was over $1 billion a year in extra overhead costs.

Members of this body will remember, because many of them were members of the State legislature in 1974 and thereafter, when the Federal Government passed new laws to correct that problem. But did we do away with all the Federal grants that had caused the oversupply? No. What Congress passed was a new act, a national health planning bill "to prevent unnecessary development, establish priorities for development of needed facilities, and monitor the use of Federal dollars."

Appreciate what happened. You have a Federal program to solve a problem which instead it makes it worse, and the answer is another Federal program with more Federal control. You cause a problem with Federal control, and then to solve the problem you created with Federal control, you go with more Federal control.

Why should I mention this? It is because this is a pattern. What we have done on a regular basis for the last 50

years is interfere arbitrarily in the controlling of health care, cause a problem, and use that problem as an excuse for additional Federal interference instead of going back and solving the problem to begin with.

It is as if this Chamber and some of its Members had amnesia, that they forgot that it was the Federal action that caused the problem.

Many will remember the health planning program because it involved the certificate of need process. It involved spending millions and millions of dollars on new regulations, on new controls. But incredibly the big cost did not come at the Federal level. It came tragically and incredibly on the State and local level to try and comply with the Federal bureaucratic requirements.

Mr. President, just an example, because I think it speaks for itself, in 1975 the health care planning legislation authorized $125 million for construction and modernization grants to help build facilities. However, the health care planning legislation in 1975 also authorized $119 million for planning processes—red tape, bureaucrats, paperwork, offices.

What did we really get for the $119 million of paper shufflers? How many people were cured of their illness because of the new bureaucracy, the new offices and the new paperwork? Mr. President, none were. Almost as much money as was authorized for the grants for construction and modernization, was authorized for the bureaucracy. Federal action, Federal control, developing a problem, using it as an excuse for more Federal control.

In 1965 Medicare was enacted. It was designed to provide health care coverage for our senior citizens. Our distinguished majority leader referred to the program earlier and characterized some of those who have criticized his plan.

Mr. President, I will not deal with that other than to say that the distinguished majority leader has not been with me in my State. He did not accurately characterize what I say to my constituents. I would hope that we would not be involved in personal attacks.

It seems to me, the question here ought to be to deal with the facts and the issues, not question the character of others. The question before the body is the legislation and I think that is the appropriate approach.

One should not forget what happened in 1965. When the Medicare Program came up and was passed, legislators rightly asked how much is it going to cost, not just that year but the next year and the years out. The figures are there. Medicare part A—not part B, just part A—alone was estimated to cost $9 billion a year by 1990. Some will remember it actually cost $66.9 billion in 1990, more than seven times greater than what had been estimated; seven times greater.

We also ought to look at what happened along the way. As the costs in the Medicare Program began to go out of control, skyrocket out of control, Congress tried to act. In 1983, as the CPI and the medical CPI diverged and the medical CPI grew much faster than the regular CPI, Congress began to realize that there was a problem.

Let me just for a moment mention those CPI figures because they tell an interesting story. For those who honestly believe that Federal regulation is the answer to control costs, please look at the facts. Before Hill-Burton, going back as far as we have separate figures for the overall CPI and the medical CPI portion, we see this.

From the period of 1939 through 1946, before Hill-Burton, the average annual increase in year-to-year figures from the Department of Labor was 4.2 percent for the overall CPI. But the medical portion of this, before the Hill-Burton law was enacted, for the same years averaged 2.5 percent. The medical portion was 1.7 percent under what the actual CPI was. That is fairly logical, when you think about it. Medical care was dragging dramatically. Industry, where you have rapid advances in technology, tends to have a lower increase in the cost. But that is 40 percent less, comparing 4.2 percent annual average increasing cost generally to 2.5 percent in medical cost for those 8 years.

What happened when we went to more Government regulation and more Government control under Hill-Burton? For those of you who honestly believe that regulation is the answer, please look at it.

From 1947 through 1965, the average CPI increase was 2.6 percent. But this time, the medical CPI, instead of being below the average overall CPI, was not less, it was more. It was 3.8 percent, 1.2 percent higher, or 46 percent more. The facts are this: Before you had the added Government regulation, the medical CPI averaged 40 percent less than the regular CPI. After you added the Hill-Burton programs and the regulations, it was 46 percent higher.

What happened when you passed Medicare and Medicaid? Did it hold down the costs? Because that is what they talked about. Take a look at it.

In 1965, the medical CPI was 2.4 percent. In 1966, it almost doubles to 4.4 percent. In 1967, up to 7.2 percent. In the years since we adopted Medicare and Medicaid, the average CPI has been 5.6 percent. The medical CPI was 7.6 percent. That is 2 percent a year higher on the average.

For those who honestly believe that regulation from the Federal level is the answer to controlling costs, please look at the facts. They indicate exactly the opposite. They indicate clearly and unequivocally that the greater regulation that is involved in this enormous bill is not going to hold down prices. It is going to increase them. And I am going to go into exactly why it will increase them in just a moment. But it should not be lost on Americans, as we consider even more regulation, that the medical CPI has been 36 percent higher than the full CPI since we passed Medicare and Medicaid.

By the time we got to 1983, it became clear that the Medicare costs were simply out of control, that we had to do something.

Federal failure; problem. What is the answer? Congress decided what was needed in 1983 was more Government regulation, and they enacted the Medicare Diagnostic Related Groups, the DRG's, designed to control the payment to hospitals by prospectively setting rates based on similar diagnoses. So DRG's were held out as the new regulatory tool to control costs.

For those who are watching, they can see the chart. This is the increase in Medicare outlays, and here is where DRG's came in. It was meant to stop the increase. That is how it was billed—more Government regulations to stop the increase.

What happened? In 1984, the consumer price index was up 4.3 percent, but the medical CPI was up 6.2 percent. The medical CPI was up almost 50 percent more than the regular CPI.

In 1985, the regular CPI was 3.6 percent and the medical CPI, 6.3 percent, almost double after you passed the 1983 DRG Act.

In 1986, the regular CPI was 1.9 percent. The medical CPI was 7.5 percent, more than three times as much.

Mr. President, please, please, our Members should take a look at the results of more Federal regulation and the impact on this process. To believe, as I know many Members do, that if we simply have more regulations, more controls, more statutes, that we are going to reduce costs is simply fantasy.

Let me share something with the Members, because I think many of us come from various walks of life and have not had a chance to deal with operating a medical office or a hospital. But, Mr. President, let me share one thing with you that I think is typical in every Member's hospitals at home.

Twenty years ago, the Greeley Hospital in my hometown, or the Northern Colorado Medical Center, as it is now called, had more beds than it has now. With more beds, they had five full-time people in medical records. Mr. President, after reducing the number of beds in the hospital, they now have 50 people in medical records. They have gone from 5 to 50.

Why have they gone from 5 to 50? Because the flood of new Federal regulations and the variety of ways in which they have responded to get paid and expand their income. If you want to reduce costs, you do not reduce it by increasing the number of people in medical records from 5 to 50.

Let me just share with the Members one quick thing. If you are trying to comply with the regulations we already impose on people, just for Medicare and Medicaid, not for Blue Cross/Blue Shield, not for the private insurers because those are additional to it—just for Medicare and Medicaid, one of the items you are going to want to have is a Medicare Topical Law Reports. They are put out by the Commercial Clearinghouse. These are simply the laws and regulations and practice guidelines. There is no fluff in here. These are simply what we impose on people. For those of you who have used these volumes you know they are on extremely thin paper and very small print. This is simply the regulations and the laws and the practices put forth. I put them here because I hope Members will take a look at them. On very thin paper with very small print, there are almost 15,000 pages of laws and regulations and practices. Why do the health care costs go up? Why does Greeley Hospital go from 5 to 50 in their medical records division? Why is it almost impossible to monitor this in a proper way? It is because we have buried the health care profession in paperwork and red tape.

The thesis that the way to deal with costs is through another giant bill and more regulations and more Federal control is just plain goofy. Before Members impose this on the American people, please take a look at what we have done to the American people already. Please take a look at what the system has to respond to. The reason costs go up is because of what the Federal Government has imposed on them in the mistaken belief that if we just add some more Government regulations we will solve the problem.

There are 5 volumes here on thin paper with small print; 15,000 pages. As I count it they average about 915 words per page, probably a little more. That is kind of a low average. If you read regulations and statutes at 300 words per minute—Mr. President, I know you are an attorney. I know there are many attorneys here. I do not know of an attorney who would dream of reading a statute or regulation at 300 words per minute; a novel, perhaps. But let us say you could and you did, and you read at 300 words per minute for these laws and these regulations, and you read 8 hours a day without a coffee break, and you read 5 days a week with no holidays, and you read week after week after week with no vacations. It would take you 5 months to simply go through this once—not memorize it, not know it, not work with it—simply to skim through it.

Can anyone honestly believe that what we need is more regulation to control cost? What has happened is we have added to the cost.

Congress did not stop after their failure in 1983, and after their answer of more regulations. In 1986 Congress came back to it again and they noted the huge continuing increase of medical costs higher than the CPI. In 1986 Congress responded once again—a Federal failure, a problem—responded with more Federal controls. In an attempt to control physician charges under Medicare, Congress passed a reconciliation bill which establishes maximum allowable actual charge limits, MAAC's. I am sure all Members are intimately familiar with that.

How can we even talk about more of this stuff? We cannot even remember the names or the acronyms that we use. MAAC's, here it is on the chart. In 1986, did it stop the increase in prices? Of course not. Prices continued on up. In 1987 the CPI went up 3.6 percent, but medical costs went up 5.6 percent, 2 percent higher. More regulation meant more cost, not more control. So, in 1989, after experiencing the failure of 1946 and the failure of 1967 and the failure of 1983 and the failure of 1986, in 1989 we came back and Congress, in response to the Federal failure and the problem, responded by adding more Federal control. Congress instituted the Resource Based Relative Value Scale. For those who like acronyms, it is the RBRVS. And the Medicare Volume Performance Standard, MVPS. This was to cover payments to physicians.

(Mr. ROCKEFELLER assumed the chair.)

Mr. BROWN. The RBRVS is a fancy fee schedule. It takes into account time, skill, overhead differences. MVPS was an attempt to control costs by discouraging volume increases for services Medicare was paying less for under the RBRVS's. Did this solve the problem? The effort in 1989 resulted in this: In 1990 the CPI was 5.4 percent and medical CPI was 9 percent. That is right—it was almost double. Far from reducing the cost of medical care it increased it. Why did it increase it? It increased it because it added more regulations, more controls, more paperwork, more bookkeepers.

In 1991 the regular CPI was 4.2 percent and the medical CPI was 8.7 percent. In 1992 the regular CPI was 3 percent, medical CPI 7.4 percent, well over double, almost 2.5 times as high.

To contend that the answer to our problems is yet more Federal control and regulation simply is to ignore the cold, hard facts in front of us. When the President came to office he promised four things. He promised the American people health care reform, welfare reform, deficit reduction, and the downsizing of our Government.

It appears he may scuttle all three to achieve health care reform. To pretend that this is a downsizing of the Government is silly. It is a dramatic increase. Distinguished speakers on this floor have talked about how this is not socialized medicine. But no one has said that it is not intimate Government control of the very details of the way almost every aspect of health care is administered and provided. To suggest this fits with downsizing of Government is simply not true.

Mr. President, here are the facts. The Clinton-Mitchell bill provides 55 new bureaucracies. Does anybody really think that is downsizing? It involves 177 new State mandates. It involves 815 new powers for the Secretary of Health and Human Services. It involves 83 new duties for the Secretary of Labor. It involves 6 new responsibilities for the Office of Personnel Management. It involves 49 new responsibilities for employers to comply with.

Let me repeat that. Employers who are trying to be competitive in a world market now have a list of 49 new responsibilities that they have to comply with. There are fines and penalties and potential prison sentences if they do not get the paperwork right.

Does anybody honestly believe that will make America more competitive in the world marketplace? Does anybody understand what it takes to comply with this?

To suggest this is the way to reduce cost is a joke. Here is what CBO says. These are not Republicans. The CBO folks are appointed by the leadership of both the House and the Senate and that leadership as everyone in this Chamber knows are both Democratic. Here is what CBO says:

> For the proposed system to function effectively new data would have to be collected, new procedures and administrative mechanisms developed, and new institutions and new administrative capacities created.

They conclude by saying:

> There is a significant chance that the substantial changes required by this proposal and other strategic reform proposals could not be achieved as assumed.

That is what CBO says. That is not what Republicans say. That is what CBO says. Under the Clinton-Mitchell bill, the Federal Government would regulate virtually every aspect of health care. Let me repeat that.

Under this bill, the Federal Government would regulate almost every aspect of health care, from what kind of insurance package people are allowed to buy, to where they get it, to how many specialists can be trained in a given year.

It restricts the choices of health care benefit packages. Earlier, the distinguished majority leader talked about what he felt were inaccurate descriptions of his package. Mr. President, there is no doubt that it does restrict the choices of health care benefit packages.

Under the Clinton-Mitchell bill, small employers are required to join a purchasing cooperative, and employers with fewer than 500 employees are prohibited from self-insuring.

Under Clinton-Mitchell, medical students may not be able to choose their

future. The Government will decide how many of any specialty are trained in any year.

Under Clinton-Mitchell, health plans may have to accept certain providers, even though they are not the best or most efficient provider of a service.

Under Clinton-Mitchell, many people will have to give the Government details about their most intimate personal lives to qualify or continue to qualify for subsidies. Are the American people ready for that? This is a country that balks at having an ID card.

Mr. President, one of the things that concerns me most is a discussion we have had with regard to insurance coverage. I have already talked about the commitment we have to health care and the way insurance coverage is used as a mechanism to expand Federal control. But one of the concerns I have is the language we use.

I have served 10 years in the House and 4 in the Senate. Every year I have been here, I have fought and urged and cosponsored measures that would extend to small businesses the same breaks that the giant corporations get. Under the Democratic Congress, large corporations can deduct 100 percent of their health care insurance costs. There are some limits with regard to policies, but big corporations can deduct it all. But under the Democratic Congress, small businesses that are unincorporated can only deduct 25 percent.

That is not fair. When I say "Democratic Congress," I say it because that has been the controlling mechanism, but one should not believe that Democrats in this country do not want that change, and many Democratic Members of the Senate want that change, as well as Republicans.

But each year that I have cosponsored that bill, it has gone to the Finance Committee in the Senate or the Ways and Means Committee in the House, and they have turned it down. The majority of people without insurance in this country today work for small businesses or have a member of their family work for small businesses. The number one thing we could do more than anything else to expand insurance coverage, if that is the goal, is to give small businesses the same deductibility as giant corporations get. It is not only fair but it is good policy. It is not overwhelmingly expensive, but it makes a big, big difference in insurance coverage.

How is it, how can it be that the Clinton-Mitchell bill does not give that equal deductibility to small businesses? If that is really the goal—if that is really the goal—to expand insurance coverage, why is it this bill does not have 100 percent deductibility for small businesses that big companies have? Once again, small entrepreneurs, individual entrepreneurs are being discriminated against. Ironically, giving them the same deductibility would do more to expand insurance coverage than all the mandates we can talk about here.

The Congressional Budget Office notes as follows:

> Senator Mitchell's proposal would discourage certain low-income people from working more hours or, in some cases, from working at all because subsidies would be phased out as family income increases.

Here is one of the problems with the bill. If you work for a living, in many jobs, particularly if they are with a corporation, you get health care insurance. Some of the plans are good and some are not so good, but generally they have health care insurance. But if you do not work for a large business, chances are you might not have health care insurance unless you buy it yourself.

You might have health care and you might have Government assistance for health care, but you do not have health care insurance. One of the reasons to go to work, one of the reasons to get out of bed in the morning, one of the reasons to roll up your sleeves is because you are better off and your family is better off if you go to work.

This takes one of the advantages of going to work and staying off welfare and shoots it right in the head. The clear message of this bill is if you are lower middle income, the Government has come up with a new way to discourage you from getting a job and getting out of poverty. That does not make sense.

We have talked about the desperate need to change the welfare system, and this is the biggest welfare program that has ever been talked about, in this bill. What it says is if you work for a living, you are going to get treated the same way as if you do not work for a living, even though you are able bodied, even though you are able to work. Mr. President, if you are able to work, I think you ought to live better than if you do not work. To destroy one of the incentives for people being productive and creative is foolish policy. The CBO, I think, has it right when they criticize it this way.

The CBO analysis goes on, and I quote again:

> CBO estimates the effects of this proposal are unavoidably uncertain.

It is a giant bill. I can understand that. It is a difficult process. We can all understand that. But look back at what happened with Medicare part A. It was supposed to be $9 billion by 1990, and it ends up being more than seven times that high.

In 1987, Congress created a disproportionate share program to assist hospitals serving the disadvantaged. CBO estimated that in the third year after enactment, the program would cost less than $1 billion. In reality, it actually cost $10 billion. That is a 1,000 percent mistake. Let me repeat that. The program 3 years out was literally 10 times what the CBO estimate was. And we start off with a CBO estimate in which they say that their estimates of the effect of the proposal are unavoidably uncertain. Is that good management? Is that good government?

The costs that are identified in this bill for businesses in the State of Colorado in the year 2002 are over $1 billion. Let me repeat that. In Colorado, in the year 2002, Colorado businesses will be hit for over $1 billion just to cover their portion of the cost of this bill. $1,015,439,000. Colorado is a small State, Mr. President, certainly in population, not in area.

The cost of this bill is gigantic and it is uncertain. The impact of more regulations, I believe, is going to be to increase costs, not to reduce them or control them. The history of Government action makes it very clear that this is not going to slow down costs. And why do costs go up as we regulate and regulate and regulate? We have already looked at the CCH reports, the Commerce Clearing House reports.

The CPT-94 is for reporting service codes for services and procedures performed for fees. It is 859 pages. In other words, if you are going to bill somebody, you cannot say I saw Mr. Jones and I treated her. You have to look up the codes, 859 pages of it.

The Medicare part B answer book, 1,600 pages of regulations. If the bill passes, this goes up, not down. The ICD-9-CM—does that sound like Martian talk?—two volumes of it, approximately 1,143 pages. These are simply classifications of diseases—a code book of classifications of diseases. Does anyone wonder why costs are skyrocketing? We cannot even get all of these things on a desk.

The HHCPCS-Cannons, Procedures and Codes, 226 pages. Does anybody think this is an efficient way to run a railroad? Medicare Physicians ID Number Manual—this is simply to identify them, and it is only for a few States—172 pages. Physicians' Desk Reference, this is a drug compendiums. These are not the Library of Congress. These are simple things that physicians and health care providers have to deal with every day if they are going to provide health care and bill Medicare. What we have done is take the greatest medical minds in the world and see if we could bury them in paperwork. Drug Evaluation Subscriptions, three volumes, 1,720 pages.

Mr. President, if regulation was the answer, if more laws were the answer, if Federal control were the answer, surely our health care would be free by now. How many more of these books and volumes do we have to impose on people before we figure out that they are part of the problem.

What we ought to be doing is not repeating the mistake we have made in 1946, in 1965, in 1983, in 1986, and in 1989.

We should not be recognizing the problem and deciding to deal with it by more Federal control.

What we ought to do is sit down for a moment and go back and get real solutions. What are they? I sponsored five major health care resolutions, legislation that was offered here, but I want to go through quickly a couple of the proposals that I think are important.

It would be inappropriate for me not to mention at this moment that last year, on April 27, 1993, after continuous delays by the majority in bringing up health care, Senator SPECTER brought forth his amendment to S. 171. Senator SPECTER was ready and able and willing to debate health care right then and there. He had asked continuously and repeatedly, and repeatedly the leadership of this body had turned him down.

Finally, he came to the floor and, in spite of their wishes, offered his amendment to reform health care, and I joined him, not because I agreed with everything in his bill but I agree with much of it. This body decided more than a year ago that they would not consider it. All this gnashing of teeth because we have not finished a bill that we just simply received the final copy of last Friday seems strange when you understand that more than a year ago the leadership of this deliberative body refused to let Senator SPECTER even bring the subject up.

Senate 1865 by Senator MCCAIN and S. 493 by Senator COHEN are bills to enable health care facilities' cooperation to better serve their markets, either allowing them to join or to form joint ventures to share equipment or by forming community health authorities. In other words, Mr. President, the proposal which is picked up in a number of other bills is to modify our antitrust laws and to see if we cannot get people to share facilities and equipment. It increases the usage and reduces the cost. That is a good idea and that will reduce cost. We ought to do it.

Senator GRAMM has talked about insurance reforms to address the problems of portability, and that is a good idea. I think that can make the system more efficient.

Senator CHAFEE has introduced a bill that I joined him to have ob/gyns be designated as primary care givers. I believe that should be passed.

We have already talked about how we ought to change our tax laws to allow full deductibility for small businesses. That should be passed.

There is a proposal in a number of these bills to provide for a medical savings account. What it does is simply allow people to have some discretion about how their health care money is spent, and that should be passed. I believe it would help reduce cost.

We ought to allow small businesses to pool together to get health care insurance buying power, just like large corporations do, and that can help reduce cost.

We ought to have meaningful tort reform, and every Member here knows it. That would help reduce frivolous lawsuits, speed up the time for payment when there is medical malpractice, and eliminate some of the waste and abuse in the system. And yet this bill, instead of making progress on medical malpractice, would take it the other way. It would gut a number of proposals that Colorado has made which are more advanced than the Federal level.

Colorado has made real progress in this area. In 1988, Colorado enacted a package of medical malpractice reforms that assured that the resources are available if the provider injures a patient but puts appropriate limits on how such claims are brought. Physician malpractice premiums have fallen by 53 percent since Colorado enacted its reform.

Mr. President, let me repeat that. Since Colorado enacted those reforms, the physician malpractice insurance has dropped 53 percent. This bill would have the effect of repealing some of Colorado's reforms. That is not progress. That is not reducing cost. It is increasing it.

Mr. President, I am convinced that we ought to provide incentives in the way we administer Medicare and Medicaid for providers to reduce cost. We ought to be smart enough to provide real incentives so if someone really does reduce the cost of a health care procedure, they share in that cost savings. Incentives will do much more than regulation to get us back on the right track.

We ought to reduce unnecessary paperwork requirements. Senator BOND has introduced a bill that will do just that, to simplify it. And I am glad to see some other proposals have picked out a portion of that.

Mr. President, this body voted on and all but one Senator in this body voted for legislation on the blood pathogen regulations. For those Members who remember that vote and remember how they voted, I urge them to review those regulations. Does someone going to medical school for 4 years or 7 years know enough to wipe off the table his patients change on?

Well, I hope so. Yet we passed these regulations that mandate and check on it and require more paperwork. Those blood pathogen regulations were some of the nuttiest, wasteful, abusive procedures that we have passed. If you talk about unnecessary paperwork and ridiculous expenses, they epitomize it. There was only one vote in this Chamber against those silly regulations. But if we were serious about controlling costs and expanding real medical care to people, those are the kinds of things we ought to look at.

But we should not look at another flood of regulations and statutes and controls and guidance. We ought to look at real reform. We ought to look at real medical malpractice changes. We ought to look at real incentives to reduce the cost. We ought to fight for ways to make this system more efficient, not less efficient.

I am in favor of medical reform, but it is not this bill. It is a bill that has a dramatically different purpose. It is one that recognizes the answer to problems created by Federal regulation is not more Federal regulation. I do not know how anyone living in the latter half of this century could look around at what has happened in the world and come to the conclusion that central Government planning and regulation is the answer to economic problems.

The simple fact is in every country on the face of the Earth that has tried it, it has been a failure. What is needed are incentives for individuals to be productive and creative. This bill does the opposite. In short, I believe we ought to put our faith in the hands and the minds and the creative spirit of individuals and expand their freedom and opportunity and choices, and that we ought to turn our back on the efforts to regulate the minute details of how our medical system works.

I yield the floor, Mr. President.

The PRESIDING OFFICER. Who yields time?

Mr. MOYNIHAN addressed the Chair.

The PRESIDING OFFICER. The Senator from New York.

Mr. MOYNIHAN. Mr. President, by previous agreement, I yield the remainder of our time, indeed, the time equally divided this evening, to the distinguished Senator from Florida, a former Governor, deeply involved in these matters.

May I say, Mr. President, that the Senator from New Jersey [Mr. LAUTENBERG] may come to the floor and may wish to speak. But after the 2 hours has expired, the floor is open for those who wish to speak.

Mr. MURKOWSKI. Mr. President, I am just going to make an inquiry.

The PRESIDING OFFICER. The Senator from Alaska.

Mr. MURKOWSKI. If I may ask the Chair, what is the remaining time?

Mr. MOYNIHAN. I believe 47 minutes. Well, I will ask the Chair.

The PRESIDING OFFICER. The Senator from New York controls 45 minutes.

Mr. MOYNIHAN. Forty-five.

The PRESIDING OFFICER. And the Senator from Oregon controls 8½ minutes.

Mr. MURKOWSKI. I thank the Chair.

The PRESIDING OFFICER. The Senator from Florida.

Mr. GRAHAM. Mr. President, in the past few days we have had a chorus of pronouncements that national health care reform was moving from the intensive care ward to the morgue, that Congress is hopelessly gridlocked, that

partisan bickering has escalated into warfare, that the American people have given up in disgust in our collective inability to accomplish anything significant, and that we have fundamentally abandoned any expectation that we can act in their interest.

Mr. President, I disagree. The distinguished majority leader has, in my opinion, skillfully moved the debate forward by introducing a solid and constructive proposal that moves the Nation forward toward the goal of universal coverage. And many reasonable people, on both sides of the aisle, are now recommitting themselves to work toward a nonpartisan prescription for the widely acknowledged ills of America's health care system—excessive cost, inadequate personal, and family health security, and gaps in services provided, particularly those which maintain health.

Some examples: Senator JOHN CHAFEE, a long-time leader in the area of health care reform, and now a leader of the Senate's mainstream coalition, has said:

> It is essential that any health care reform measure pass by a very, very strong majority in this body * * * I seek a program that is going to pass here 80 to 20 or 70 to 30, a healthy, strong, bipartisan support for that measure on the floor of the Senate.

Senator BOREN agrees when he says.

> * * * the only way we're ever going to get the deficit under control and sustain a long-range approach is to have a bipartisan plan, one that will have the support of a vast majority of the American people in both our political parties. And the only way * * * that we're going to have health care reform carried through in an efficient and effective way is to reach a bipartisan consensus so that the plan can be sustained for many years* * *

And to quote one additional of our colleagues, Senator COHEN has stated:

> The decisions we make in the coming weeks are going to have a profound consequence for every single American. They are going to control the future direction of one-seventh of our Nation's economy. And we shouldn't even begin to contemplate enacting sweeping reforms unless they're broad-based and bipartisan.

Mr. President, I believe there is a clear formula for this bipartisan prescription, the basis for which is already in the majority leader's bill. We should build upon the genius of the Federal system. We should equip States and localities with the appropriate tools so that they, working with their citizens, can tailor health care reform to their unique circumstance. The role of the national Government should be to establish goals and to monitor the attainment of those goals.

The case for a decentralized health care system is compelling. Some of the points which make that case compelling include diversity as the key underpinning of the American health care system. Health care is particularly suitable to the establishment of national goals with decentralized implementation, and sensitivity to local cultural, geographic and institutional variations. States, and communities within States, have different health care needs based on societal factors such as the quantity and nature of health care providers.

For example, Nebraska, North Dakota, and South Dakota have twice the number of hospital beds as Alaska, New Hampshire, and Hawaii. Varying demographics, especially among the most health intensive populations—for example, Florida, Pennsylvania, Iowa, Rhode Island, and the State of the Presiding Officer of West Virginia—have 50 percent more elderly than do Alaska, Utah, Colorado, and Georgia.

Current levels of insurance coverage is another area of extreme difference. In Nevada, Oklahoma, Louisiana, Texas, and Florida, approximately one-quarter of the population under 65 is uninsured. Whereas, in Hawaii, Connecticut, and Minnesota, less than one-tenth of the population under 65 is without insurance.

Mr. President, clearly State circumstances require different solutions and different timeframes. For example, what would work in a rural area would not work in a highly urbanized area. The means of achieving universal coverage and access are undoubtedly different in Florida than they are in Wyoming.

Another point which I think makes the argument for a federalized system compelling is that the Federal Government is frankly ill-equipped to build or operate a unitary health care system.

The experience of nations with a long history of universal access health care systems—just to mention two, Germany and Canada—have shown that implementation requires decentralization. Our Nation is significantly more populated, geographically larger, and infinitely more diverse than either Germany or Canada. A successful plan would have to accommodate the broad diversity of the United States through decentralization.

Yale professors Theodore Marmor and Jerry Mashaw make this point in a July 7, 1994 Los Angeles Times editorial:

> Given the diversity of States, their varied experience with health care and intense local preferences, why enact a single brand of national health care reform, especially if it's the poorly-considered compromise that we seem to be headed towards? By moving compromise in the direction of preserving goals rather than defining means, we can allow States the further thought and experimentation that are needed for effective implementation.

Mr. President, States have also demonstrated their creativity and ability to implement complex health care initiatives, often in the face of stiff resistance from the same Federal agencies that would be placed in charge of a proposed unitary system.

In health care reform, States have significant experience and success. The summer 1993 issue of Health Affairs chronicles health care reform successes at the State level in Hawaii, Maryland, Minnesota, Oregon, Washington, and Florida. Significantly, each of these States have adopted reforms that differ in terms of scope, anticipated outcome, and processes. These variations reflect the diverse needs, ideology, and stage of health care evolution in each of those States.

So should national reform. Only then will we have real accountability, and responsiveness to the needs of consumers, businesses, and providers. Only then will we have health care reform that actually is able to deliver sustained accessibility to high-quality, affordable health care for all Americans.

Hawaii offers the best example of a State's creativity and ability to accomplish the goals of positive health care reform. In 1974, Hawaii passed a comprehensive health care reform proposal that included virtual universal access, financing through a shared responsibility between employer and employee, and a serious commitment to the prevention of illness.

As we celebrate the 20th anniversary of this State's initiative, we should take note of the following: Hawaii has the highest percentage of its citizens covered by insurance—over 96 percent. In Hawaii, the cost of insurance coverage for small businesses is 30 percent below the average for small businesses in the United States. Hawaii's infant mortality rate is 6.7 deaths per 1,000 live births. This compares to 9.2 deaths per 1,000 live births for the Nation as a whole. I believe the President would agree that those are compelling statistics of a success which started at the State level, started with citizens in a particular State responding to that State's circumstances to meet the goals and aspirations of its citizens.

Hawaii was fortunate in being able to develop and implement its health care reforms with the cooperation of a Federal administration also committed to health care reform—that of President Richard Nixon. Hawaii's reform system was also implemented prior to the enactment of significant restraints on the State's ability to innovate, such as the Employee Retirement and Income Security Act [ERISA].

Other States have not been so fortunate. My own State of Florida has experienced the frustrations of many States that have attempted to innovate, to be a center for reform, to be that laboratory of experimentation which is at the heart of the Federal system.

In the mid-1980's while I was Governor, Florida was unsuccessful in its attempt to receive a waiver from the Federal Government for a Medicaid buy-in program. The purpose of that program was to allow the working poor who were otherwise without insurance to be able to share with the State and

the Federal Government in accessing the Medicaid Program. The waiver that would have been necessary to make that possible was denied by the Reagan administration.

The current Governor of Florida, and our former colleague, Lawton Chiles, is making a similar effort, called Florida Health Security, to provide health care coverage again to the working poor. Florida Health Security would provide subsidies to uninsured working Floridians to purchase private health insurance. Participants would contribute a portion of their premium based on their incomes. Employers could voluntarily contribute a portion of their employees' premiums. The program would be paid for using Federal and State savings in Florida's Medicaid Program, realized primarily by enrolling Medicaid recipients in managed care plans. Florida Health Security would provide 1.1 million uninsured Floridians with health insurance coverage, and through this single initiative, this one initiative, raise the percentage of Floridians with coverage from the current 82 percent to 92 percent.

However, just as was the case a decade ago, Governor Chiles is now faced with foot-dragging and ho-humming from the Health Care Financing Administration, the agency that must grant the waiver. Why? Why has there been this reticence to allow States to innovate? A New York Times article dated June 12, 1994, may provide an answer. According to the article, Mr. Bruce Vladeck, administrator of the Health Care Financing Administration, warned in a June 1993 memorandum:

> The waiver authority could become a way of relaxing statutory or regulatory provisions considered onerous by the States.

He added that waivers "will be used to slow down nationwide reform."

Mr. President, after over 6 months of review, Florida's waiver application is still pending in the Health Care Financing Administration bureaucracy.

Mr. President, I applaud the majority leader for his able leadership in moving the Senate toward consensus on health care reform. I believe his proposal provides the basis for a decentralized health care reform system. His bill allows for compliance with the national intermediate goal of 95 percent coverage by the year 2000 on a State-by-State basis. The majority leader's proposal rejects the concept that there must be a single national standard by which compliance is judged.

Specifically, Senator MITCHELL proposes that by January 1, 2000, 95 percent of the population in each State must have health care insurance coverage. In those States that fail to meet that goal, businesses would be required by the year 2002 to pay half of the cost of insurance for their employees and their families. Businesses with fewer than 25 workers would be exempt from that requirement.

I applaud the architecture of the majority leader's proposal. This State-by-State evaluation will fundamentally shift incentives and challenges. The plan will motivate States to develop their own reforms exactly to avoid the Federal prescription, while at the same time providing health care insurance coverage to their citizens.

Again, if I could, Mr. President, I believe there is a case study of this in Florida. Ask any provider, insurance, or business association in the State, and they will tell you that it was the threat of Federal action which was the impetus that brought all of the parties to the table to develop Florida's health care reform plan. Fifty individual State triggers, rather than a single national trigger, will cause States to accelerate their activities in order to achieve a 95 percent objective and avoid falling into a Federal mandate. States will also clearly understand that they cannot adopt policies which tolerate, much less contribute to, additional health care costs, without jeopardizing their ability to achieve the prescribed 95 percent level of coverage by the year 2000.

Senator MITCHELL's call for a State-by-State approach acknowledges variations among the States and recognizes that innovation must be tailored to the circumstances of individual States and communities.

Mr. President, this State-by-State evaluation gives States substantial control over their own destinies. Only through a decentralized evaluation of performance will States feel compelled to take aggressive action to reach the 95 percent coverage by the year 2000.

While Senator MITCHELL's bill lays the groundwork for a decentralized system, some modifications are necessary to reach his proposal's maximum potential. Such modifications could be grouped around the following principles: We should avoid Federal action which increases health care costs and then shifts those costs to the States. For example, S. 2357, the majority leader's proposal, would create three subsidized programs. One would be for mothers and children. A second would be for individuals who were formerly served through Medicaid, and a third would be a general subsidy program. These three would be in lieu of a single streamlined subsidy program. States would be required to administer the subsidy programs without Federal assistance for administrative costs. The Congressional Budget Office estimates that States will be required to spend an additional $50 billion to administer these three programs over the next 10 years. We should also avoid policies that restrict the abilities of States to chart their own course.

For example, S. 2357 would calculate State maintenance of effort payments using an annual growth factor based on the rate of increase in national health care spending.

Using a national calculation rather than a State-by-State calculation penalizes those States that have already taken steps or will be encouraged to take steps to reduce health care costs and rewards those States that have not acted to control costs.

Also, States should not be held accountable for cost factors that are beyond their control, including federally prescribed increases in benefits and increases in the quantity of health care services due largely to the population's aging.

We should also avoid measures which have the unintended effect of punishing States which are implementing or proposing initiatives to expand coverage, to move toward that goal of universal coverage.

Under S. 2357, currently eligible Medicaid beneficiaries would not have their benefits reduced under the new subsidy program. While this is a laudable goal, I believe this provision penalizes States which have chosen to provide optional services beyond those required of Medicaid.

Such States would then be locked into those benefits while States that provide only the minimal Medicaid services would not.

In addition, States would be required under the majority leader's bill to provide benefits over and above the standard benefits package to individuals currently enrolled in the Medicaid program. These so-called wrap-around benefits would be matched by the Federal Government at the State's Medicaid match rate.

This requirement will add to State administrative costs, but more importantly, it raises a fundamental equity question by subdividing the low-income population into two groups, one group those who had previously been under the Medicaid program, the other group those who had not been under the Medicaid program, and provides a differential level of benefits at State administration and significant State cost to the former Medicaid eligible population.

We should, also, Mr. President, provide broad waiver authority from Federal statutes and regulations to facilitate State innovation.

This is not a new concept. In 1992, our colleagues, Senator LEAHY and Senator PRYOR, introduced legislation that would provide incentives to States to achieve comprehensive, State-based health care reform. I was pleased to be a cosponsor of that legislation.

This proposal should serve as a basis for an expanded waiver authority in S. 2357 so that States who want to take control of their destiny different from the Federal plan would be permitted to do so.

Mr. President, we should also eliminate requirements for which national uniformity is not essential.

Federal preemptions of State laws and Federal standards should meet the

following fundamental test: Does the desired goal require national uniformity in process or procedure, or can the desired goal be accomplished without Federal mandate and prescription?

Two examples within S. 2357, in my judgment, fail to satisfactorily answer this question. They are the essential community providers provision. This is a provision which will require a certain group of providers to be covered under all plans. I see no reason why States should not have the flexibility to determine whether there are within that State essential community providers and, if so, who they are. There is also a preemption of State licensure laws for medical professionals. States have traditionally exercised authority in this area. I see no reason why that authority should be shifted.

Mr. President, States should also be given a broader range of options should they fall short of the 95-percent coverage goal by the year 2000.

Under S. 2357, a State that fails to meet the 95-percent goal would be subject to new Federal standards adopted by Congress after considering recommendations from the newly created National Health Care Commission.

Should Congress fail to enact such provisions, the State would be required to adopt an employer mandate with employers paying half the cost of coverage for employees and their families. Employers with fewer than 25 employees would be exempt.

I believe a State which fails to achieve the 95 percent goal should have an opportunity to present a corrected plan to the Health Care Commission. The plan would be subject to Commission approval and would detail how the State would reach the 95 percent goal by the year 2002.

Under this construction, the employer mandate would be triggered if, and only if, the State plan is rejected by the Commission or if approved by the Commission the State fails to accomplish the goal of 95-percent coverage in its implementation.

States that take this second chance option would have the opportunity to learn from those States that had been successful in meeting the 95-percent goal. The Health Care Commission could also use these success stories of those States that had met the 95-percent goal to evaluate and assist deficient States in achieving the goal of 95-percent coverage.

Mr. President, health care reform is too important to the fundamental objectives of individual Americans and our Nation as a whole to languish or to be lost. I believe that we are close to a course of action which offers considerable promise of accomplishing our collective goals.

However, our goals will only be realized if we allow for maximum decentralization in their implementation. It only will be realized if we avoid impeding the imagination and the commitment of millions of Americans to health care reform in their communities and in their States.

These are good citizens who, with a spirit of community and common sense, will find not one but a thousand roads which will merge at the common national destination of an affordable health care system that will provide quality health care services for all Americans.

Thank, you Mr. President.

The PRESIDING OFFICER. The Senator from Alaska.

Mr. MURKOWSKI. Mr. President, I thank the Chair.

(Mr. GRAHAM assumed the chair.)

Mr. MURKOWSKI. Mr. President, let me note for the RECORD, as this debate continues, everybody on both sides of the aisle is truly supportive of health care reform. So really the issue is, how to achieve that in the best interests of the American public.

I am sure that many who have followed this debate are somewhat concerned with the mechanics of the health care proposals because indeed they are quite complex, but there are a few things that the American public understands.

They understand availability of health care. They want availability of health care, and they want that availability at the minimum cost with the most coverage. Availability also is synonymous, of course, with portable. They want the assurance of being able to have their health care insurance follow them from job to job.

But the American people are also concerned about aspects of the Mitchell bill, which is before us. And one aspect that certainly has caught the attention of a lot of people is the suggestion that approximately 100 million people will be subsidized by the Mitchell plan. That is out of a population in 1990 in the United States of 248 million people. Approximately 100 million will be eligible for some type of subsidy.

That does not ring very well with the American people because they are also concerned about the expanded bureaucracy. They do not want to see any more agencies. They do not want to see some 34 new Federal boards and commissions. They are concerned about just what 117 new mandates really mean, and the States are concerned because some of these mandates are directives to the States that are unfunded.

What the public really wants in a health care plan, in addition to cost control and availability, is the assurance that there is some accountability. You know how Government responds with accountability. Government runs off and hires more compliance officers in each agency as opposed to holding the head of that agency accountable for the actions of that agency.

And the public is concerned, of course, about the Government going into the health care business. The point has been made sometime in this body that if you like the Post Office system in Washington, DC, you will love the Government once it takes over health care.

What can we learn from observation of our neighbors in Canada? We can learn some interesting things, Mr. President. One that strikes me is that approximately 21 percent of the budget in our neighboring nation of Canada is interest on their debt. What is that attributed to, Mr. President? That is attributed to escalating health care costs associated with the Canadian system.

They are also concerned with the realization that in Canada today, in Saskatchewan, many hospitals are being closed. Many Canadians come from Vancouver to Seattle, come from Toronto and other areas to Buffalo, NY, for health care simply because of availability and quality.

So as we embark upon this effort, Mr. President, let us keep in mind what the American public wants. They want availability. They want cost controls.

And the task before us is a monumental one in trying to achieve that. We are achieving that in the sense of working in a bipartisan manner for health care reform. But it is how we go about this task. And we must continually remind ourselves that good intentions are not enough, because good intentions will not make up for bad policies.

In our desire to improve access to what is already the highest-quality health care system in the world, we cannot afford to turn that system over to an army of bureaucrats and well-meaning idealists. We have to look very carefully at the reform proposals before us before we leap into a full-scale change.

What we want to do is obviously maintain the quality that we have and make the improvements when they are needed. But we do not want to throw out the baby with the bath water, so to speak.

The health care reform debate has evolved dramatically over the last 9 or 10 months. It is kind of interesting to reflect on the public approval of the President's reform proposal, because the fact is that public opinion for approval of the President's program has fallen steadily, as the implications of a major overhaul become more and more clear. As a consequence of this extended debate and the efforts of my colleagues to try to bring out the particulars, the public is beginning to understand and is becoming more concerned with availability and escalated costs and Government bureaucracy. And it has affected the President's reform proposal and its acceptance.

A majority of Americans now want incremental, targeted reforms or no reforms at all until we better understand the sweeping social changes that we are proposing.

The fact is that none of us can fully understand the implications of this legislation without this extended debate. The Clinton-Mitchell bill is predicted now to cost up to $1.1 trillion over the first 8 years in new entitlement spending, becoming the third largest entitlement program in our budget.

How do we fund that, Mr. President? Well, if the past is any indication, we fund it by deficit financing. What is deficit financing? It is simply everything else you need to add to the deficit and you pay interest on it as part of the budget process. You could not do it with your own checkbook, Mr. President. But we can do it here in Government.

Have we not learned from the Medicaid and Medicare spending explosions of recent years that we cannot accurately predict the true burden of this massive new entitlement and what effect it is going to have on our future generations? We are mortgaging the future of our children and grandchildren, Mr. President.

The bipartisan Commission on Entitlement and Tax Reform, cochaired by my colleagues, Senator KERREY and Senator DANFORTH, reports that, by the year 2012, existing entitlements and interest on the debt will consume all of our Federal tax revenues.

Think about that for a minute. By the year 2012, existing entitlements—we are not talking about entitlements for health care—existing entitlements and interest on the debt will consume all of our Federal tax revenues.

Mr. President, you and I both know at that stage, we are broke.

A major new Government-run health care program will, in all likelihood, bring us to the point of national bankruptcy even sooner than the year 2012 if we do not address up front just how we are going to pay for it.

As Robert Samuelson of the Washington Post recently stated, the "something for nothing" deception being played out on the American people regarding new health care entitlements is an "exercise in national make-believe." Well, he is right on target, Mr. President.

The proposal before us would create at least 34 new or expanded federally run boards and commissions—and they cost money—to determine what benefits each American would be allowed, with the burden of implementing as many as 117—you have heard it before—new mandates passed on to individuals States. The bipartisan National Governors Association warns that:

> Under this bill, States will take on significant new responsibilities to administer, monitor and enforce compliance of a new restructured health care system * * * set entirely by the Federal Government. It is expected that States will have to administer * * * but have little flexibility to set their own standards.

This is tragic, because States are the laboratories for change and innovation in health care reform. It is critical that reform proposals recognize State autonomy and the need to be flexible.

My State of Alaska, for instance, is carefully considering comprehensive health reform legislation, and already has in place high-risk insurance pools to make insurance accessible to those who would otherwise be uninsurable under the current system. Alaska law currently prohibits denying coverage because of pre-existing conditions and we have established a Small Employer Reinsurance Association and several small business reinsurance pools. There is broad recognition, in my State, that some of the central principles being put forth in the Clinton-Mitchell plan, such as encouraging managed care models of health delivery, do not work in areas where there is limited or no access to even the most basic health care services. Alaska is not the only State with unique circumstances. Every State has unique qualities that can make Federal dictates counter-productive.

But the plan before us does more than establish new bureaucracies and State mandates.

While almost everybody agrees that one of the factors forcing health care costs up is the cost of litigation, it is my understanding that the Clinton-Mitchell bill actually provides funding for lawyers to help people sue their own States if, in fact, federally mandated health plans are not implemented properly. No wonder the American people are nervous.

The premise behind the bill is misguided. It proposes to meet the need of insuring the 37 million people in this country who do not currently have health insurance by providing a Federal subsidy to more than 100 million people. I cannot understand the logic behind creating an entitlement program that will cover more people than are now covered by Medicare, Social Security, and Medicaid combined in order to resolve the uninsurance problem for 37 million people, many of whom will find insurance on their own without Government assistance.

In creating this new system, the Clinton-Mitchell bill actually raises the cost of insurance to middle-income families. The bill raises the price of all insurance policies in this country by $145 billion through a new taxes on, of all things, health insurance. Even the Congressional Budget Office [CBO] finds one of these taxes—the 25-percent tax on so-called high cost plans—so poorly designed that it will effect virtually all plans, and increase premiums so much that it will discourage participation in the health insurance market.

That is a diplomatic way of saying that the taxes in the Mitchell plan will force more people to become uninsured. What is even worse is that the health insurance plans that will pay the biggest tax are plans that insure a large number of sick and old people, and efficient managed care plans. What is the logic of such an ill-conceived tax?

And while the middle class pays more taxes, others get a free ride. In fact, starting in the year 2002, if the employer mandate is triggered, it appears that the cost of health insurance for individuals will become free. It may surprise my colleagues to know that, but according to section 10135 of the bill, which deals with health insurance premium payments, it states: "In no case shall the failure to pay amounts owed under this Act result in an individual's or family's loss of coverage." In fact, the bill assumes that many enrollees will stop making payments and sets up a system known as the Collection Shortfall Add-On which will raise premiums for all participants in the plan to cover the cost of those who fail to make payments.

Mr. President, it is obvious to this Senator that many will simply not pay their health insurance premiums once they realize that their coverage cannot be canceled and they are assured that they will be covered for any health related expenses.

I believe there is a better alternative to the legislation before us. An alternative which would make great strides in providing access to care for the uninsured, without sacrificing individual choice, State flexibility or radically restructuring one-seventh of the American economy. I heard my thoughtful colleague, Chairman MOYNIHAN, comment on the floor last week that it would certainly be a shame if Congress did not at least act on those reforms which we know have a broad consensus of agreement—reforms such as making insurance portable, removing restrictions on preexisting conditions, voluntary insurance pooling for small business, and subsidies to help the most needy purchase private insurance. I agree. I think we may have lost sight of the areas where most of us agree, where we can tackle problems of rising costs and inadequate access today rather than spinning fragile webs of government run health care that don't go into effect for years down the line.

Mr. President, I want to comment on a critical area of our health care system that also tends to get lost in the shuffle in the debate over national health care reform—that area is our Federal medical programs. Today the Federal Government is not just a payer of health care bills, as in Medicare and Medicaid, but is also a direct provider of health care through programs in the Departments of Veterans' Affairs, and Defense, the Indian Health Service, and the Public Health Service. In Alaska, 34 percent of total health care spending is for Federal health programs. As the ranking Republican on the Senate Committee on Veterans' Affairs, I notice that these programs, and the lessons we can learn from them, have

largely been overlooked in the debate over reforming the private health care system.

As most of you know, the Department of Veterans Affairs [VA] health care system is the largest single health care system in the United States. The VA health care system consists of 171 hospitals, 353 outpatient clinics, 128 nursing homes, and 37 domiciliaries. The annual budget for VA health care is currently $17.6 billion, which provides care for approximately 2.2 million veterans and employs over 209,000 health care workers. In addition to basic health care services, the VA provides specialty services like spinal cord injury, blind rehabilitation, post traumatic stress disorder and other mental health services, comprehensive homeless programs, and long-term care and geriatric programs. These are all excellent programs—their equals cannot be found in the private health care system.

Because of our commitment to our veterans, taxpayers have made a huge investment in VA health care, an investment that we do not want to waste. But proposed health reforms may well provide those who now use the VA with alternative choices of care—GAO predicted that if universal coverage was passed, up to 50 percent of current VA users would go elsewhere for care. The effect is that the VA will have to compete with other providers or die on the vine—to consolidate and better manage care or lose patients.

Unfortunately, the VA is not now in a position to compete—nor are they used to competition. The VA does not know basic cost and other information needed to establish premiums, sell services, or operate in other basic business ways. It will take 3 years before the VA has a system installed nationwide to determine even basic information on what it costs VA to provide specific medical procedures. The VA remains too facility oriented, as oppose to health care delivery oriented. It is burdened with underutilized inpatient hospitals, and lacks the outpatient capacity and the community presence to adequately meet the comprehensive needs of veterans and their families.

Until we know what final product Congress will produce, be it the Clinton-Mitchell plan, the Dole-Packwood plan, the Gephardt plan, or a little bit of everything, it is difficult for us to say what is needed for the VA. In the Veterans' Committee markup of VA health reform, I offered an amendment that would have delayed implementation of VA reforms until we knew what national health reforms looked like. While I did not succeed in passing this amendment, I believe its purpose still holds true—we are moving into uncharted waters.

The Mitchell health plan does not clear up any of these unknowns—in fact, it creates new ones. Under the Mitchell plan, in order for veterans to receive a comprehensive benefits package, they would be required to enroll in a VA health plan. Core group veterans—such as the service-connected disabled and the poor—would receive free care. For veterans and their family members who have outside coverage, the VA would retain Medicare reimbursements and private third-party reimbursements. These reimbursements, in addition to regular health care appropriations, would supposedly pay for the comprehensive benefits for all core group veterans.

The problem is that there is no way to know if the increased reimbursements will offset the increased costs. There are currently 2.2 million users of the VA health care system. But as many as 7.5 million veterans would qualify for free care under the Mitchell plan. Most of these veterans do not currently use the VA system, but might if benefits were free. Third-party reimbursements and regular health care appropriations together may not be sufficient to cover the increase in enrollment and the extension of new, free benefits to those who are currently not eligible to receive them.

I am also concerned that, the Mitchell bill, on the one hand seems to create a new entitlement program for veterans health care, while, on the other hand, it also makes expenditures subject to the ordinary appropriations process. The effect is that the Mitchell plan could result in a reduction of care to veterans. If appropriated dollars were not sufficient to pay for each veteran's care, then all benefits would be reduced to make up the shortfall. In essence, a veteran signing up for a VA health plan that promises a certain level of benefits would not be assured that those benefits will remain available. Furthermore, veterans who now receive comprehensive benefits from the VA might see their level of care reduced. Again, we are speculating because we have no idea how many new users a VA health plan would attract into the system. But a thorough reading of the Mitchell plan would suggest that the so-called reformed VA health system could be detrimental to the VA by not even protecting the level of care certain veterans enjoy today. I understand that the majority leader and Senator ROCKEFELLER are considering an amendment to fix this problem and I look forward to seeing their solutions.

That said, there are simple ways that we can help VA run its programs to better serve veterans and not break the bank. Earlier this year, the Senate passed a bill to let the VA participate as a provider in States that are undergoing health reform. The point of this legislation is to free up VA facilities from VA Central Office control, to let them innovate, to contract freely for health care and other services, to give directors of the medical centers more freedom from personnel regulations. In short, the pilot bill was designed to make VA more businesslike, more managed-care oriented, and therefore more competitive by placing considerable authority in the field. The Dole-Packwood proposal includes many elements of this proposal and would expand it's scope to include any VA facility which wishes to participate in the plan, and allow the VA to collect from Medicare for non-core group veterans.

These reforms hold promise. Minnesota now allow any department or agency of the Federal Government to organize an Integrated Service Network to compete with other health plans in the state. The Minneapolis VA Medical Center currently leases excess space to a private HMO for an outpatient clinic. Montana is also studying ways to integrate Federal health programs like VA, IHS, DOD, and Public Health. And there are other examples of states that are moving on their own. We want VA to be able to adapt to these changes.

Mr. President, America's health-care system is the best in the world. It is the product of collective genius, scientific advancement, and modern technology, flourishing in America's private sector. There is no doubt that Government has aided and even fueled some of this progress, particularly in technology and science, but never before has government, especially the Federal Government, advocated to so directly manage the system, as the Clinton-Mitchell proposal would do, if it were to become law.

As many others have stated and written, this is a historic time for the Senate and for the country. I disagree, however, with the pundits and some of my colleagues who say that it is time to abandon America's privately managed health care system.

So we have many questions to answer with regard to the Mitchell bill, and just that one aspect of VA health care and how that is going to fit in as well. I could comment at great length as well on how the Indian Health Care Service is going to fit in to the proposed national health care plan because these, indeed, are going to provide groups that previously had utilized these systems exclusively with the opportunity to go out and have the choice of other alternative types of care.

In conclusion, let me say what we want to do is what is right for the American people. But the voters are going to be our judge. I fear the judgment will be harsh, should we take the wrong course at this time, a course that, once taken, cannot be reversed.

So I remind my colleagues the concerns of the American people, indeed, are health care reform but not at any price. Health care reform that addresses costs. Health care reform that addresses availability and portability.

Not an expanded bureaucracy, not a subsidy for 100 million American people. Not a program that establishes another 34 new Federal agencies. Not a program that establishes 117 mandates. And not a program that mandates to States certain policies that are unfunded.

The public is concerned about health care. The public is concerned about the bureaucracy. Let us address a pattern of uniformity here that addresses the concerns of the American people.

We should enact a bill that fixes what is wrong—and fixes only what is wrong. Let us not get in the way of what is right. Moderation and prudence are what the people expect of us, and no less. If we—with all good intentions—move America's wonderful, unique health care system down the road to a rationed, poor quality, one-size-fits-all system, what good have we done? Have we then fixed what is wrong or have we wronged a great system? Our voters will be our judge, and again, I fear that judgment will be harsh should we take the wrong course; a course that, once taken, cannot be reversed.

The PRESIDING OFFICER. The Senator from South Dakota.

Mr. DASCHLE. Mr. President, we made progress today. I think we can all be pleased at the passage earlier this evening of the Dodd amendment. It sends the right message as we begin debate about health care reform. It says to the country, it says to all of those who are watching, it says in particular to children that, indeed, they are a priority.

There is some symbolism in the passage of an amendment dealing with children as our first amendment, a statement that as we consider building a better health care system, we consider children. We are told they are 33 percent of our population but 100 percent of our future.

Just last weekend my oldest daughter had her birthday. She is now 23. I cannot think of a better present than to say to her and to say to all of those who are beginning their young adult lives: We can promise you a better future, a more secure future, a future with an appreciation for the importance of preventive care.

So as we begin this debate I hope it is an indication, not only of the symbolism that I believe it represents, but clearly a constructive beginning in a debate that ultimately will lead us to meaningful health reform.

Earlier today many assembled not far from here to remind all of us that as we now debate this issue, since the beginning of the debate, since the day the majority leader laid the bill down, 500,000 additional Americans lost their health insurance; 100,000 children were included in that 500,000 Americans. People from all over—people from Florida, people from South Dakota, people who are wealthy, people who are not, people who are sick, people who are healthy—but 500,000, half a million people have lost their health insurance since this debate began. About 48 a minute now lose their health insurance.

During the time the Senate has been considering the children-first amendment, the amendment offered by the distinguished Senator from Connecticut, children, too, have continued to suffer.

In those 4 days, 2,544 babies were born to mothers who received late or no prenatal health care; 3,204 babies were born at low birth weight, which was less than 5 pounds; 224 babies died before they were 1 month old, just in the last 4 days; and 440 babies died before they were 1 year old just in the last 4 days.

So, Mr. President, this is a problem that ought to be very clear to all of us. The ramifications of failure are stark. These profound statistics speak with an exclamation point that we must deal with this issue effectively.

About 9 million children in the United States went without health insurance 2 years ago. It is about 15 percent of all the Nation's children. About 80 percent of uninsured children have at least one employed parent, and over the last 5 years, between 1987 and 1992, the number of children with employer-based coverage decreased by almost 5 percent. Children now under 21 comprise almost 30 percent of the population, but 36 percent of the Nation's uninsured. And that affects utilization.

Children without insurance are less likely than those who are insured to use the health services or to have any usual source of medical care. In 1992, the vaccination levels for children between the ages of 19 and 35 months of age were 83 percent for measles containing vaccines and diphtheria, tetanus and pertussis, DPT, shots and 72 percent for polio.

Three-fourths of the children in this country between the ages of 19 and 35 months were able to achieve some meaningful vaccination levels, but one-fourth did not. In 1990, an estimated 3 million children under the age of 6 had unacceptably high levels of lead in their blood. And as of June 30 of last year, over 4,700 children in the United States had been diagnosed with AIDS. AIDS is now the fastest growing cause of death for adolescents.

Deaths of children due to homicide have tripled since 1960, now becoming the fourth leading cause of death among children ages 1 to 9, the third leading cause for children ages 10 to 14, and the second leading cause of death for adolescents ages 15 to 19.

Every dollar spent on measles, mumps, rubella vaccine saves $17.80 in direct health care costs according to the Department of Health and Human Services. It costs about $20 for a doctor's office visit to treat a child with strep throat, but thousands to hospitalize a child whose untreated strep throat develops rheumatic fever. Between 1989 and 1991, a measles epidemic struck over 55,000 Americans, more than 11,000 were hospitalized, costing lives and millions of wasted dollars.

An estimated 3 million children under the age of 6 had blood levels so high that CDC considered it dangerous.

So, it is very clear, the cost of preventive care has an astounding effect on the population, both in cost as well as healthwise. It returns tremendous investments to vulnerable children as well as their families.

Improving health of infants and children early and comprehensive prenatal care alone saves $3 for every $1 invested according to a study by Health and Human Services. Children who receive regular health screening, such as those provided through Early and Periodic Screening, Diagnosis and Treatment Program, have health costs 7 to 10 percent lower than other kids.

Cases of measles, polio and other diseases have decreased by over 99 percent since the introduction of vaccines.

The estimated benefit/cost ratio of vaccines—that is, dollars saved for every dollar spent—is over 21 to 1 for measles, mumps, rubella, and 30 to 1 for diphtheria-tetanus-pertussis. It is over 6 to 1 for polio vaccine.

So given these facts, it is very difficult for me, or anybody else, I am sure, to understand our country's acceptance of such large numbers of uninsured children and families today.

Yet, each year nearly one-half of all pregnant women go without health insurance at all. Nearly all of these are women in working families. About 5 million women have private insurance policies that do not cover maternity care, and so, therefore, pregnant women without health insurance are likely to have inadequate prenatal care, inappropriate arrangements for delivery and less than adequate care for their newborn babies.

Fifty-one percent of teen mothers and 24 percent of all mothers in the United States last year received inadequate prenatal care. There cannot be a better argument for the Dodd amendment. I am surprised, given all these statistics and given the ramifications of what the Dodd amendment could really do, that it was not 100 to 0 tonight.

Infant mortality in the United States has declined to 8.9 per thousand live births. The United States, however, still has a higher rate of infant mortality than 22 other industrialized countries, a rate more than double that of Japan. Over 90,000 babies were born to mothers who did not see a health care provider during pregnancy—90,000 just last year alone. These babies are three times more likely to be born with low birth weight than those whose mothers received a timely prenatal care.

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Unfortunately, Mr. President, close to 40,000 infants die each year because their mother had no prenatal care and because there were complexities and difficulties that they did not anticipate because they had no place to go, because they had no insurance and no options. That is what we are talking about tonight: An opportunity for pregnant mothers, for families to say never again, to say at long last we are going to do what we said we were going to do for a long period of time. We are going to cover them right from the start. We are going to do what other industrialized countries have done now for so long. We are going to try to improve that infant mortality rate, we are going to do better than being number 22 and we are going to start doing it this year.

Mr. President, that is really what the Mitchell bill begins to do. It proposes that all children be covered with full coverage by the year 1997. Almost immediately it begins to cover 6 million children. It covers additional millions of families with children who would be given discounted premiums for the first time, premiums recognizing that prenatal care in that basic benefits package is so important to us and to all of those who are struggling today.

There are 2 million people who today are kept from obtaining health insurance because they have preexisting conditions, and the Mitchell bill says we are going to put an end to that. Upon passage of this legislation, that will no longer be allowed.

So all told, Mr. President, we add those who have no coverage, we add those who have some coverage but cannot afford the pregnancy care that ought to be in every plan, along with those who have preexisting conditions, and we now total more than 9 million children who ultimately, if this legislation passes, will be covered.

The coverage is designed for children with preventive services that include the immunization that I just discussed, with special services that recognize special needs, such as rehabilitation services for those who need them, an essential nutrition through the WIC program, recognizing first and foremost that with good health will come good nutrition, with good nutrition comes an opportunity to send the right message to young families today, that preventive care is dependent upon good nutrition, good meals, and healthy children.

Mr. President, the Dole bill leaves out more than 6.2 million children. If that bill were to pass, there would be no insurance for more than 6 million of the 9 million uninsured today. Lewin-VHI, the analytical firm in Virginia, upon whom we have turned on many occasions for good evidence or good analysis of what plans will do under different circumstances, has reported to us that the Dole bill, at most, covers 2.8 million of the current 9 million children who are uninsured. But by 1997, as I said, the Mitchell bill covers them all. Children under 19, pregnant women living in families with incomes below 185 percent of poverty will receive full premium subsidies. In other words, they will be given the full opportunity to acquire meaningful health care right from the beginning, phased in, as I said, through the year 1997.

Under Dole, however, the insurance companies will dictate which coverage children will have. Insurance companies would be in the driver's seat. They decide which benefits to cover and which to exclude. Therefore, many children will still be prevented from getting the well-child visits, the prescriptive medicines, or the preventive services that are so critical if, indeed, we turn around the statistics that I outlined just a moment ago.

Many children, though their parents' work, will continue to be excluded from coverage since parents will be covered by employee-only policies that do not cover dependents. But under the Mitchell bill, children are guaranteed solid coverage regardless of circumstances, regardless of for what employer their parents may work. Health plans cannot be terminated, limited, or restricted. They cannot charge more based upon a child's health status. Insurance companies cannot charge more for a medical condition. They cannot charge more for claims experience or a medical history. They cannot charge more if a child has a disability. Insurance companies have to treat all of our children the same. Nor can they limit, restrict, or terminate coverage, or charge more because a child has used a lot of health care services in the past for whatever reason.

The bill closes loopholes that leave children uncovered today. It spells out coverage for children even if they are adopted, even if they live with grandparents, even if they have stepparents or other guardians. In all circumstances, Mr. President, children are covered. The priority that we laid out in the Dodd amendment is extended, enhanced, and completely covers the children that are left out in the cold today. It guarantees that no matter what, we will have an insurance policy that at long last covers them all, regardless of circumstance, regardless of age, regardless of health.

The Dole bill provides no help for children in need of long-term care. It offers no new long-term program that provides for opportunities for children to live outside of institutions today. So without that opportunity to live in alternative care settings, many children under the Dole bill will be restricted to the institutions that they try to avoid now because they will have no other option.

But the Mitchell bill creates a new long-term care program that provides individualized care for disabled children, provides for a Federal-State, home/community-based, long-term care program with emphasis on individual needs.

So here again, Mr. President, as we have talked about the many differences between the Dole bill and the Mitchell bill, there is a recognition of the stark difference. We have talked on many days now about why it may be that the Mitchell bill is twice as long as the Dole bill. Simply put, it does twice as much—for children, for seniors, for working families, for small businesses, for insurance reform and creating the opportunities to do the real kinds of things that we all say we want: Containing costs, providing good universal coverage, making sure that we have meaningful insurance reform, and doing the kinds of things that we have all spoken about the need for for many months now. That is what the Mitchell bill does.

So as I said at the beginning, Mr. President, we have made a good start today. We passed an important amendment. We recognize that there are 100,000 children today who had insurance when this debate began. How many more children will lose their coverage during the course of this debate? Will it be another 100,000, 200,000, a couple million? That all depends upon us.

When all is said and done, when we have an opportunity to say at long last to those who wait for action, to those who truly believe that we can solve this problem, let us answer affirmatively, let us say that what we did today is more than just symbolic; that, indeed, it is indicative of the kind of strong belief we must demonstrate that we can solve this problem for children, for families, for all Americans.

I yield the floor.

Mr. GORTON addressed the Chair.

The PRESIDING OFFICER. The Senator from Washington.

Mr. GORTON. Mr. President, what is the state of debate in the Senate at this moment?

The PRESIDING OFFICER. The 2-hour time period which had been allocated has expired. Any Senator is able to be recognized and to speak on the legislation.

Mr. GORTON. Mr. President, I ask unanimous consent to speak for roughly 10 minutes on a different subject, on the crime bill.

The PRESIDING OFFICER. The Senator has that right.

CRIME BILL CONFERENCE REPORT

Mr. GORTON. Mr. President, earlier today, the distinguished chairman of the Committee on Judiciary of the Senate spoke on the so-called crime bill which still is pending in the House of Representatives. The chairman stated that he could not understand why Republicans claimed that community

notification of sexual offenders was dropped from the conference report. The chairman claimed that the conference report does, indeed, include community notification.

So that I can be entirely accurate, I wish to quote briefly from the statement made by the distinguished chairman of the Judiciary Committee. He stated that the conference report, and I quote:

> Requires the States to create registries of sex offenders; requires law enforcement to keep track of those offenders' whereabouts after the release from prison; and the provision explicitly permits law enforcement to give notice to the community to serve law enforcement purposes and to give the police immunity from releasing that information.

The chairman of the Judiciary Committee's attempt to correct the RECORD on the contents of the crime conference report, Mr. President, itself needs correction. As a sponsor of the community notification language legislation in the Senate that was attached by this body by unanimous consent, I totally and completely disagree with his statement. Instead of providing for notification to communities when convicted sexual predators are released from prison and into individual communities, the conference report provides for a section expressly establishing privacy protections for those very sexual predators.

And I want to state precisely what appears in the crime bill. Under the title "Privacy of Data," it says:

> The information collected under a State registration program shall be treated as private data on individuals and may be disclosed only to law enforcement agencies for law enforcement purposes or to Government agencies conducting confidential background checks with fingerprints. A law enforcement agency may release relevant information concerning a sex offender required to register under this section when such release of information is necessary to carry out law enforcement purposes or to notify the victims of the offender.

Mr. President, if this were not so serious, that would be gallows humor. The only member of the public ever entitled to notification of the presence of the sexual predator is a victim of that offender, and that victim very frequently, Mr. President, is in fact dead. The general public has no such right under this legislation, and in fact, under these privacy provisions, the general public may not validly be given that information even presumably by the authorities of those States such as my own which already have such provisions in their law.

My amendment, adopted unanimously by this Senate in November of last year, entitled the "Sexually Violent Predators Act," the acceptance of which was instructed upon the House Members of the conference by a rollcall vote of 407 to 13, but which was dropped by the conference committee, is based on a successful registration and community notification law in the State of Washington that has provided protection to countless potential victims of these monsters.

The community notification element, letting a community, a neighborhood know when these predatory men are released into their neighborhoods, is crucial to the success of preventing repeat offenses. Had such a provision been in effect in the State of New Jersey, the recent notorious and terribly regrettable Megan Kanka murder almost certainly would not have taken place. Her parents did not know that three sexual predators were living across the street from them, one of whom eventually brutally murdered that 7-year-old victim.

It is true that the conference committee report provided for registration and tracking of sexual offenders in a certain fashion. It failed to include language, however, expressly providing for the notification of the community without which the registration and tracking is almost useless. In fact, as I have already indicated, for all practical purposes, it forbade any such community notification except of previous victims, either already traumatized or perhaps dead.

The term "law enforcement purposes," which is included in the conference committee report, is not defined. Perhaps the chairman of the committee suggests that this includes the ability to notify the community of the presence of a released sexual offender. That certainly is not clear to this Senator, and certainly it should not ordinarily be included in a section, the title of which is "Privacy of Data." It would take enormously good faith for a law enforcement agency to believe that "law enforcement purposes" clearly permits community notification other than notification of a previous victim.

There is a phrase, a section on immunity, for law enforcement agencies for good-faith conduct in the conference report. But that immunity is going to be meaningless if the law enforcement agency goes beyond the explicit language of the act itself.

This was not the only thing that the conference committee did to strip the provision of any effective meaning for communities and for potential victims. It also weakened other sections of my amendment. Rather than requiring these repeat sexual offenders who, the chairman of the Judiciary Committee and I agree, often have the least possibility of rehabilitation, the least percentage record of rehabilitation of any of our major criminals, to register indefinitely and to verify their addresses every 3 months, the conference report limits the registration to an arbitrary 10-year period and only requires registration once a year. Again, Washington State and the other States that have adopted such provisions find that those provisions and the tightness of those provisions are absolutely essential for success in monitoring these very, very dangerous criminals.

I believe, Mr. President, that we must be absolutely clear if we are going to provide law enforcement agencies with the authority and the direction to share this information, and if we are going to provide citizens with the protection that they need and deserve. And I believe that the rights of those peace-loving, law-abiding citizens and their children are greater than the privacy rights of convicted sexual predators.

We have to include expressed community notification provisions like those in the Senate amendment which was adopted on my suggestion here last November.

Let me tell you what people in the State of Washington think about these various provisions. Catherine Dodd, of Families and Friends of Violent Crime Victims, writes to me:

> The highest obligation of our government is to protect its citizens. We ask that you do everything in your power to retain Senator GORTON's community notification provision for sexually violent predators. The Nation as a whole needs this provision.

Bob Ross of Citizens Against Violent Crime, writes:

> We believe firmly the lives of our children will be saved if you support this measure. We ask that you please retain this provision regarding sexually violent predators.

And Kelly Rudiger of The Crime Victims Bureau writes:

> A crucial component of the Federal crime package is the community notification provision for released sexual predators. Our organization is in support of this measure and requests that you retain this provision in the pending crime package.

All of that advice was ignored. Once again, the purpose of the amendment in the first place was to encourage the establishment of a national registration and tracking system so that interstate movement of these sexual predators could be followed, and then to see to it that communities and neighborhoods knew it when their new neighbors were released, convicted sexual predators.

My amendment did so by withholding a small amount of law enforcement money from the States that did not establish such a system. The conference report, on the other hand, gives the Attorney General complete discretion over whether a State can be denied these funds. They have far less incentive, therefore, to comply than they did under the original amendment.

Finally, the conference committee report does not make it clear whether or not States can take more significant and more drastic measures to notify communities. They need that authority very, very specifically.

Mr. President, notification of communities and the broad use of the knowledge about the presence of sexual predators was a vitally important part

of the Senate version of the crime bill. For reasons which are still obscure, in spite of instructions from the House of Representatives, it has been dropped from the present bill. It is one of the great shortcomings and great defects of the crime bill pending before the House of Representatives today.

The attempt by the chairman of the Judiciary Committee to justify what was done and to say that community notification remains in the bill, is simply incorrect. It is not there. To make this bill even remotely or minimally acceptable to many persons concerned with what happens to their children, concerns with the repeat sexual predator, it must be restored in its complete and in its original form.

Mr. LAUTENBERG addressed the Chair.

The PRESIDING OFFICER. The Senator from New Jersey.

Mr. LAUTENBERG. Thank you, Mr. President.

I wanted to deal with the subject of health care. But since our distinguished colleague from the State of Washington talked a bit about the crime bill and his concern for a section of the bill that has to be strengthened, referring to notification of communities, that someone who has had a history of sexual attacks on young children has to be made public so that the people in the neighborhood can be aware, is a very important addition.

I was called today by the President of the United States—twice, as a matter of fact—and he announced that he was fully supportive of the so-called Megan Kanka law. He directed his call to me because I am from New Jersey where we have had two horrible incidents in very recent weeks where very, very young children were attacked by a depraved sexual predator who not only raped these children but killed them.

So our communities are on high alert, very nervous, and parents are concerned about what is happening. The President of the United States told me that he is determined to see that the crime bill includes a very strict notification process so people in the communities can be alerted to the danger that may exist for their children. So I was pleased to hear that discussion. I am fully supportive. Senator GORTON and I were the lead sponsors in this, and we intend to push it until it becomes a matter of law.

HEALTH SECURITY ACT

The Senate continued with the consideration of the bill.

Mr. LAUTENBERG. Mr. President, I want to talk for a bit on the health care debate that has finally started. I am pleased to see that it has begun in seriousness. The moment has been a long time in coming.

Responding to the real needs of our people, the President and Mrs. Clinton proposed that we add security, universality, and cost containment to the high quality that already characterizes our health care system for those who are covered. I must confess that my own personal experiences influence the way I look at this issue. One experience is defined by what I have now. As we all know, we in the Congress are covered by health insurance largely paid for by our employers and partially by ourselves, a good health insurance, paid for principally by the people we work for, the American people. That experience makes me think that we ought to give the American people what they now give to us: Quality health care any time it is needed at an affordable price.

The second experience, Mr. President, is defined by what I used to have. Back in 1943, after I had enlisted in the Army, before I ever heard of something called health care, my father was stricken with cancer. He was 42 years old. My parents worked hard. They did not have health insurance. It was fairly uncommon at the time. As my father's illness progressed, the bills mounted. After he died, when my mother was left with what to her were enormous hospital and doctor bills, she was not able to mourn free of her obligation, free of conscience; she was forced to worry about these bills at a time when she needed to try to adjust to her life as a 36-year-old widow—I was 18—she was forced to work two jobs to pay our debts. It took her almost 2 years, month by month by month, to finally put those bills behind her. I remember it vividly, Mr. President.

A third experience is defined by what I hear from the people of New Jersey. I have listened to families in their middle age trying to help their kids get a start in life, while at the same time still often having to bear the responsibility for their parents' medical bills, or even long-term nursing home care. They cannot make it, no matter how hard they work. I have listened to the small business people, who cannot afford to buy insurance for their own families, much less their employees.

I come from a business background, and I know how pained those business people are when they find out they cannot get insurance because of skyrocketing costs or preexisting conditions or a recent illness that sends premiums through the roof.

I have listened to seniors on fixed budgets, people who are watching every penny they spend, who are afraid they may need long-term care that they cannot afford, or who already cannot afford the medicines they need. They deserve better than that. I have listened to families who have no health insurance and heard them tell me that they cannot afford to take their kids to a doctor. They have few options. They can go down to an emergency room when the illness is acute, and wait in line while everybody has their needs cared for.

Unfortunately, it is true there are 8 million American children who are not covered by some kind of a health care plan. They do not get regular checkups. They need immunization. They cannot help themselves not be exposed to sickness or disease, because they are unable to get the traditional care that most of us are accustomed to in our own families.

No family should be forced to choose between putting food on the table and taking care of their children's health, or choosing between helping with a college education or health care, or jeopardizing their own retirement to take care of parents stricken with Alzheimer's disease. But that happens in New Jersey and in our country every day of the week.

Mr. President, that is what this debate is all about. It is listening and responding to the real needs of our people and being sensitive enough and committed enough to meet those needs by undertaking fundamental reform—reform that builds on the strength of our existing system and addresses its weaknesses.

And so, Mr. President, it has been said by many here that this truly is a historic debate. But it is not a debate about a radical notion. Over the past 60 years, comprehensive health care reform has been proposed three times and defeated three times. President Roosevelt first proposed it as part of the original Social Security Act, and then President Truman proposed it and, more recently, President Nixon proposed it, and that was some years ago. Each time it was offered, those who favored the status quo prevailed, and the Congress failed to act. And now our time has come.

I agree with the majority leader when he says that we ought to stay in session as long as it takes to enact a bill. I disagree with those whose goal it is to talk as long as it takes to kill this bill, to talk it to death, or threaten to bury us with a hundred amendments. Mr. President, that tells the American people a story. "We have 100 amendments," kind of cute with a twinkle in their eye. What is that saying? It is saying: We are going to derail this health train no matter what it takes to do it. That is the message. It does not say: We will put out 100 amendments because we want to improve the bill. It does not say: These 100 amendments are going to make sure everybody has care and the children are cared for, and we will give pregnant mothers prenatal care. It says: You bring up this health bill, and I am going to make sure it goes down.

I disagree with those people; I disagree with those who choose to deride

or scorn attempts to solve this problem, who trivialize the needs and concerns of the American people. They deserve an honest debate and a real decision, a vote on amendments, and a vote yes or no on the bill itself.

Mr. President, the health care debate has centered around two major issues: Security and cost. While almost 85 percent of Americans have some type of health care coverage, an enormous percentage of us are only one pink slip or one preexisting condition away from losing that coverage. People should not lose their health insurance because they change jobs or because they become unemployed. They should not lose their health insurance because they get sick, and they should not have to pay more for insurance for these reasons.

There are 37 million Americans—over 800,000 in my State of New Jersey—who do not have health insurance coverage. Mr. President, it is important to understand something about the uninsured. They are just the homeless and the unemployed, the other people who drift around the edges of our society; they are our neighbors, they are our friends, and they are us.

Approximately, 84 percent of the uninsured work full or part time. These are people who play by the rules, work hard for a living, pay their taxes and are forced to wait to be treated in emergency rooms or go without care altogether. They have not failed to be responsible; the system has failed to respond to them. That is not what America is about.

Mr. President, perhaps the most unfair thing about our current health care system is this: both the very poor and the rich have health insurance. The rich typically get access to health insurance through their employment or their own wealth; the poor get access to health insurance through Medicaid. It is the rest—in my State, people with incomes up to $60,000 per year—that make up the bulk of the uninsured. We have created a system which provides health security to the rich and the poor, but not for middle class, not for ordinary working Americans.

If we are to continue to reduce the Federal deficit in a meaningful way, we must control health care costs. And the only way to do that is through real and comprehensive health care reform.

And it is not just the Federal budget that is affected—it is the family budget as well. Last year, the average American family spent approximately $5,000 for health care. This is three times the amount they paid in 1980. If we do nothing, our families will spend approximately $10,000 annually in the year 2000 for health care coverage.

Now, Mr. President, it is obvious to me that we have three choices.

First, we can do nothing—just leave things as they are.

Second, we can adopt a bill that Senator DOLE has proposed, which makes some needed reforms in the system but still leaves 20 to 25 million Americans uninsured. Third, we can move toward universal coverage by adopting legislation that not only reforms the insurance system, but contains costs and provides affordable access to care for the uninsured, the self-employed, and small businesses.

Doing nothing is unacceptable. It also cost too much.

National health care spending has grown by over 10 percent per year for the last 10 years. In 1994, we are projected to spend almost $1 trillion dollars on health care—approximately 14 percent of our Gross Domestic Product [GDP]. As bad as that is, it gets worse in the future. If we do not act now, then by the year 2003 we will be spending twice that much $2 trillion per year on health care, 20 percent of our GDP. In 1980, health programs consumed 16 percent of the Federal budget. Left alone, by 1998 they will be 35 percent of Federal expenditures.

One of the problems we have in the present system is called "cost shifting." That simply refers to the fact that you and I pay the costs that hospitals and doctors shift to patients with insurance in order to cover the cost of their unreimbursed care. So if you are working, and you and your employer are paying for health insurance, you are not only paying for your own health care, you are also paying for those without health insurance. The only way to prevent that—the only way to keep your premiums affordable and fair, is to cover everyone.

And when we cover everyone—which the Dole plan does not do—people will get the care they need sooner, before illnesses become more acute, more difficult to treat, and more expensive to cure. Those 20 to 25 million Americans the Dole plan leaves out will increase the costs that you and I pay as health care costs continue to climb.

The third alternative is to move toward universal coverage, which is what the President proposed and what Senator MITCHELL is aiming for.

Senator MITCHELL's plan is simpler and less bureaucratic than that which was originally proposed by the President. It builds on our private system of health care delivery and insurance. It preserves patient choice and provides a cushion for small businesses and less affluent Americans seeking to insure themselves and their employees. It would stop the kind of cost shifting we now experience, and put an end to the insured picking up the tab for the uninsured. It seeks to cover at least 95 percent of all Americans by the year 2000; the Congressional Budget Office has confirmed that the bill should reach that target.

This bill will move toward universal coverage more slowly than the President's original, because it depends more on reform of the insurance system and competition in insurance rates rather than taxes and bureaucracy. But it does promise to extend quality health care to our people at affordable prices, whether they work for a large corporation, a small company, or are self-employed.

If these reforms do not achieve the goal of health insurance for 95 percent of the citizens in each State by the year 2000, the Congress will be required to find additional ways to expand coverage or employers will be asked to share in the responsibility of providing health care insurance. Small business will be exempt.

Mr. President, while I support the general approach of Senator MITCHELL's bill, I do want to highlight at least two areas where further review is needed.

First, the bill contains a new tax which would be imposed on higher cost health care plans. While I understand that this measure is included in this bill to help contain costs, I feel it is a punitive charge which is unnecessary and unfair to workers who have chosen jobs with generous health benefits in lieu, perhaps, of higher wages. It is also unfair to high cost States, where premiums and health care costs tend to be higher. If we have to raise new revenues—estimated to be $35 billion over 5 years—I think there are better ways to do it.

For example, I would like to increase the cigarette tax. A recent study revealed that smoking related illness costs Federal and State governments $21 billion a year. The tobacco industry should help pay for those costs rather than the taxpayer. The same can be said of an ammunition tax. Gun related injuries impose a heavy cost on our health cares system and fill our emergency rooms. All of us pay those costs. It would be more appropriate for those who profit from firearms and ammunition to share in paying for the costs they impose on society than for average Americans to pay a tax on their health care plans.

My second major concern relates to the failure to include a regional cost adjustment in the formulas in this bill so that the assistance provided to individuals and small businesses is indexed to the cost-of-living in a State. Recent figures in the New York Times listed New Jersey, along with only two other States—Hawaii and Alaska—as having a cost of living which is 20 percent or more above the national average. The relative cost of living should be taken account of in providing assistance under Federal programs for citizens of each State.

I have joined with Senator LIEBERMAN in calling for indexing of certain Federal programs to take account of the cost of living in each State. Senator MOYNIHAN, the chairman of the Senate Finance Committee,

is working on a proposal to introduce a cost-of-living adjustment into health care reform. I strongly support his efforts. New Jersey has suffered from a low return on our Federal tax dollar because of the relative affluence of our citizens. Adjusting Federal formulas to take into account the cost of living in a State makes sense and would help address this inequity.

Mr. President, while we debate health care policy, we have to remember that more than "policy" is involved here. People are involved. People who need health care. We all want to make sure that our families have health care, our mothers and fathers, children, and grandchildren—because everyone gets sick.

We have made enormous progress since 1943 when my father died. Now 85 percent of our population has health insurance. Our seniors have Medicare, the poor have Medicaid and many of us have private health insurance. But we have left a segment of society behind without health security. They are in the same situation my mother was in over 50 years ago. For the most part, they work, pay taxes, raise their families, and play by the rules. But they lack health care coverage through no fault of their own. They deserve better than what our current system provides.

Mr. President, I hope that at the end of this debate, Congress will approve a bill that moves us toward universal coverage and that President Clinton will sign it. It will be a great day for America. I look forward to working with my colleagues to accomplish this goal.

I yield the floor.

MORNING BUSINESS

Mr. LAUTENBERG. Mr. President, I ask unanimous consent that there now be a period for morning business, with Senators permitted to speak therein for up to 5 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

THE U.N. OFFICE OF INTERNAL OVERSIGHT SERVICES: A CRITICAL EVALUATION

Mr. PRESSLER. Mr. President, over the last several weeks, I have raised many concerns regarding the management problems at the United Nations. On July 29, 1994, the U.N. General Assembly adopted a resolution to create a reform office charged with the cleanup of U.N. management and budgetary malfeasance. Repeatedly, I have waged my concerns about this office [OIOS]. I do not believe that the OIOS will possess the independence necessary to offer true reform at the United Nations.

Recently, former U.N. Ambassador Jeane Kirkpatrick wrote an editorial in the Washington Post critical of this OIOS. I agree wholeheartedly with her assessment of the office as well as an assessment offered by the editorial board of the Washington Times newspaper. Additionally, the U.N. Association documented the events leading up to the U.N. adoption of the resolution mandating the creation of the OIOS in its weekly report. I ask unanimous consent to place these articles in the RECORD at this time.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the Washington Post, July 28, 1994]

AT THE U.N., DISPENSING WITH REFORM

(By Jeane Kirkpatrick)

How, you may wonder, could an organization acquire 850 minibuses that it did not need, buy a water purification system that never worked, purchase dozens of extremely expensive computers that never were used and hire highly paid, top-level bureaucrats for nonexistent jobs?

These and dozens of similar things can happen because efficiency is not a central value at the United Nations. Reform is not popular in this culture that features high salaries and lifestyles like those of the rich and the famous.

Waste, fraud, double-dipping, overstaffing and mismanagement have dogged the United Nations from its founding. By now these practices are habits in an organizational culture that protects mismanagement in the name of multiculturalism and sees efforts at reform as hostile to the organization.

The last two Americans who made a serious effort at reform (Richard Thornburgh and Melissa Wells) were forced out of the U.N. system, their recommendations ignored, their efforts unappreciated. The report of former U.S. attorney general Thornburgh on mismanagement was shredded on the instructions of the secretary general, but a few copies survived and circulate today in Washington and New York. And of course, the abuses Thornburgh described persist.

Over the years, various parts of the U.S. government have tried various tactics to deal with the waste, fraud, mismanagement and sexism endemic in the U.N. system. In the '80s the "Kassebaum Amendment" (by Sen. Nancy Kassebaum, R-Kan.) successfully used the threat to withhold 20 percent of U.S. regular contributions to gain some reform in the United Nations' budget-making process. It was a step, but only a step.

President Clinton made a personal appeal to the General Assembly for appointment of an independent inspector general with broad investigative powers. Clinton's long-delayed presidential decision directive on peacekeeping noted its concern that the United Nations "has not yet rectified" management deficiencies, and promised the administration would work for "dramatic" improvements in management of the U.N. system, beginning with the "immediate establishment of a permanent, fully independent office of Inspector General with oversight responsibility that includes peacekeeping."

The Clinton administration's top U.N. delegate, Ambassador Madeleine Albright, warned the U.N.'s Fifth Committee that "poor management can be the Achilles' heel of the United Nations," saying, "I cannot justify to the taxpayers of my country some of the personnel arrangements, the sweetheart pension deals, the lack of accountability, the waste of resources, the duplication of effort and the lack of attention to the bottom line that we often see around here." Of course, she was right. Such practices cannot be justified to taxpayers whose hard-earned dollars are being wasted.

Albright, too, called for establishment of an independent inspector general's office. But no serious move was made toward establishing the post until a bipartisan coalition in the U.S. Congress passed the "Pressler Amendment" (so called for its author, Sen. Larry Pressler, R-N.D.), which put teeth in the request. Failure to establish "an independent and objective office of Inspector General" by the end of July would result in the United States withholding 10 percent of its total (non-peace-keeping) contributions ($420 million) for fiscal 1994, and 20 percent in fiscal 1995.

The Pressler Amendment got the attention of the General Assembly, which negotiated a resolution it hopes will satisfy Congress. But the resolution calls for an inspector general who would not be independent. Instead the "compromise" provides for an inspector general appointed by the secretary general on the basis of geographical rotation and expertise, who will report to the Secretariat and can be fired by the secretary general with the approval of a majority of the General Assembly. It also does not give the inspector general an independent budget, or jurisdiction over all U.N. agencies or broad investigatory powers.

U.S. negotiators, it is reported, tried but failed to win greater independence for the proposed inspector general and lacked the time to achieve more.

One might have thought the General Assembly would feel the pressures of time more acutely than the U.S. team. But this team cannot bear the thought of withholding $420 million from its U.N. contributions and is acutely uncomfortable with threats of punitive action. So the Clinton team at the United Nations is doing what the Clinton administration so often does in its foreign policy: It is making major concessions to reach an agreement that does not really achieve the administration's goals, then presenting that agreement as a victory and further undermining U.S. credibility in the process.

Apparently the Clinton team would rather offend Congress than U.N. colleagues. The General Assembly's "acceptance" of the terms of the Pressler Amendment is rather like the Serbs' "acceptance" of the last peace plan for Bosnia. It offers the form but not the substance of compliance—and hopes that Congress did not really mean it.

[From the Washington Times, August 2, 1994]

HALF A NEW BROOM FOR THE UNITED NATIONS

Last year, when the United States pulled out most of our troops from Somalia, the idea was that U.N. troops would take over the task of peace keeping. That's generally the scenario these days, whether the talk be of Rwanda or Haiti. It's solution that has the appeal of promising Western powers like the United States or France a way out of a quagmire they do not particularly want to get stuck in. However, what happened in Mogadishu suggests the limitations of this approach. No sooner had the Americans turned over the operation than it was discovered that Egyptian troops guarding a U.N. depot were allowing Somalis to walk in and remove whatever objects they liked.

The instance is not an isolated one, of course. Last year, former Attorney General Richard Thornburgh produced a report on the staggering waste, fraud and corruption going on at the United Nations, based on his

stint there as undersecretary general for administration and management. Now, Mr. Thornburgh did not set out to produce this document as an enemy of the organization, but rather as someone who would like to see the United Nations saved from itself. He suggested that an important step would be to institute an office of inspector general to monitor the United Nation's many far-flung operations and vast, sprawling bureaucracy—according to the best estimates available, some 50,000 people, though no one knows for sure.

At the time. Mr. Thornburgh's recommendations did not evoke much of a response. In fact, he never received an official reply from U.N. Secretary General Boutros Boutros-Ghali. Nor was the report distributed in the organization. Most of the copies there were reportedly shredded. "This is not an institution that takes kindly to criticism," he told The Washington Times' editorial page. No, indeed.

An amendment offered by Sen. Larry Pressler, Republican of South Dakota, in July to the Foreign Operations Appropriations bill seems to have had more of an impact. Mr. Pressler proposed to withhold 10 percent of the U.S. contribution for 1994 and 20 percent for 1995 unless President Clinton by Sept. 30—the end of the fiscal year—can show that the United Nations has established an office of inspector general. Accountability for American taxpayers' money, and a lot of it, too, is what the Pressler Amendment is all about.

This Saturday, the U.N. General Assembly voted to give Mr. Pressler some of what he wanted. It agreed to establish an office of Internal Oversight Services, the head of which would serve one five-year term and hold the rank of undersecretary general.

While this is certainly a step on the right direction, it is a step that does not go far enough. A real question remains on how independent this office will be. This is not so much because, according to the resolution adopted, the inspector general can be removed by the secretary general backed by a vote in the General Assembly. Such a move, if politically motivated, would meet with an outcry from major donor nations. No, the problem is that the office will not be independently funded, but be part of the budget drawn up by the secretary general. That gives him considerable power over its operations.

It's too early for the White House to declare victory in the debate over the U.N. inspector general. If Mr. Clinton believes the United Nations to be as important as he says he does, he'll have to send his negotiators back to the bargaining table.

[From U.N. Association, Washington Weekly Report, July 22, 1994]

SENATE ADOPTS AMENDMENT RESTATING U.S. POSITION

(By Jeffrey Laurenti)

Reacting to reports to an impending breakthrough in the negotiations in New York, the Senate on 14 July adopted an amendment to the foreign assistance appropriations bill, H.R. 4426, that restates US requirements for the creation of an independent Office of Inspector General (OIG). Sen. Larry Pressler (R-SD), who led the successful effort to mandate the withholding of some US assessed contributions to the UN regular budget and peacekeeping operations unless the inspector general's office were created, told the Senate that the new post "would not be independent. This is an unequivocal violation of the language in the Foreign Relations Authorization Act (Public Law 103-236, Section 401)," he said. Pressler called on the Senate to adopt the amendment restating the US position to show that "the United States will not stand idly by while the United Nations slaps us in the face."

In a related development on the same day, Pressler and two Republican colleagues, Sen. Robert Dole (R-KS), the minority leader, and Sen. Jesse Helms (R-NC), senior minority member of the Foreign Relations Committee, dispatched a letter to US Permanent Representative Madeleine Albright insisting on a "stringent" interpretation of the criteria in the foreign relations authorization act, which they said "the terms of the draft resolution do not currently meet." According to the signers, "The terms establishing the office must demonstrate unequivocally the independence of the OIG and define clearly its specific oversight activities." They concluded, "The stakes are high, the opportunity fleeting. Without significant and immediate action to improve the efficiency of UN operations, congressional willingness to fund UN activities will dminish further."

SEEN AS CLINTON ADMINISTRATION SUCCESS

In New York, the creation of the inspector general post in the face of deep suspicion of Washington's motives was credited by many UN delegates as a significant success for the Clinton Administration. During the Negotiations, UN delegates frequently expressed exasperation over perceived divergences in positions within the United States Mission to the United Nations, and they complained of uncertainty about whether they were getting the views of the US Government or the Clinton Administration's critics on Capitol Hill. The resolution's drafters took much of its language from US law and US position papers in order to ease the certification the President is required to make to Congress.

LABOR RESEARCH CENTER CELEBRATES 10TH ANNIVERSARY

Mr. PELL. Mr. President, I would like to pay tribute today to one of the great educational and research facilities in the State of Rhode Island, the Labor Research Center at the University of Rhode Island.

This year marks the 10th anniversary of the founding of the Labor Research Center. The center is dedicated to teaching, research, and service programs on labor, the labor market, and labor relations.

In these last 10 years the Labor Research Center has flourished and is now considered one of the Nation's premier centers for the study of labor/management relations. Since its creation in 1984, the center has had 624 students enrolled for graduate courses who had previously studied at undergraduate institutions in 7 foreign countries, 14 States and Puerto Rico. The student body has included recent college graduates, government employees, managers in private enterprise, and many involved with labor unions.

The distinguished faculty, including Dr. Diane Disney, who has taken a leave of absence to serve as Deputy Assistant Secretary of Defense, research issues ranging from the working class during the Gilded Age to work/family conflict in the present day. Especially important to the creation and success of the Labor Research Center is center director and professor of industrial relations Ted Schmidt. Mr. Schmidt worked for 12 years for the creation of the Labor Research Center and continues to lead the center and provide undying support for the faculty.

In this age of budget cuts and funding reductions it is good to hear about an educational and research program that has thrived. So on this the 10th anniversary of the Labor Research Center, I commend the students and faculty on their success and thank them for the service they are doing for labor and business.

NAMING OF VETERANS' ADMINISTRATION BUILDING AFTER THE HONORABLE CLAUDE HARRIS

Mr. HEFLIN. Mr. President, I rise today in support of the bill offered by my Alabama colleague, Senator RICHARD SHELBY. This bill, which designates building No. 137 at the Tuscaloosa Veterans Center be named after the Honorable Claude Harris, Jr., deserves the full support of the Senate.

Claude Harris, Jr., was born in Bessemer, AL, attended the University of Alabama, and became assistant district attorney for Tuscaloosa at the tender age of 25. He later served as a circuit judge and was presiding judge of Alabama's sixth circuit for 1980–83. He was a practicing attorney from 1985 through 1987, when he began his first term in Congress. He is currently serving as the U.S. Attorney for the Northern District of Alabama. I would also like to add that he is a colonel in the Alabama Army National Guard, of which he has been an active member since 1967.

Congressman Claude Harris of Alabama's Seventh District retired in January, 1993, after serving in the House of Representatives for 6 years. During his three terms he accomplished much for his district and the Nation's veterans. I can safely say that Alabama's veterans know Congressman Harris to be a true friend. As an outspoken member of the House Veterans' Affairs Committee and third ranking Democrat on its Hospitals and Health Care Subcommittee, the work he did was instrumental in preserving the funding for, and enhancing the quality of veterans health care facilities.

Because of these years of service, I feel that the naming of this soon to be completed building at the Tuscaloosa Veterans Center is a fitting tribute to a great man and a great friend. I hope all my colleagues will join me in this small expression of gratitude and support this bill.

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Mr. Thomas, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

MESSAGES FROM THE HOUSE

At 11:57 a.m., a message from the House of Representatives, delivered by Ms. Goetz, one of its reading clerks, announced that the House has passed the following bill, in which it requests the concurrence of the Senate:

H.R. 4907. An act to reform the concept of baseline budgeting.

The message also announced that the House has passed the following bill, with an amendment, in which it requests the concurrence of the Senate:

S. 1406. An act to amend the Plant Variety Protection Act to make such act consistent with the International Convention for the Protection of New Varieties of Plants of March 19, 1991, to which the United States is a signatory, and for other purposes.

ENROLLED BILL AND JOINT RESOLUTIONS SIGNED

At 2:15 p.m., a message from the House of Representatives, delivered by Mr. Hays, announced that the Speaker has signed the following enrolled bill and joint resolutions:

S. 2099. An act to establish the Northern Great Plains Rural Development Commission, and for other purposes.

S.J. Res. 153. Joint resolution to designate the week beginning on November 21, 1993, and ending on November 27, 1993, and the week beginning on November 20, 1994, and ending on November 26, 1994, as "National Family Caregivers Week."

S.J. Res. 196. Joint resolution designating September 16, 1994, as "National POW/MIA Recognition Day" and authorizing display of the National League of Families POW/MIA flag.

The enrolled bill and joint resolutions were subsequently signed by the President pro tempore (Mr. BYRD).

At 6:17 p.m., a message from the House of Representatives, delivered by Ms. Goetz, one of its reading clerks, announced that the House agrees to the amendment of the Senate to the bill (H.R. 2178) to amend the Hazardous Materials Transportation Act to authorize appropriations for fiscal years 1994, 1995, 1996, and 1997.

The message also announced that the House agree to the amendments of the Senate to the bill (H.R. 2815) to designate a portion of the Farmington River in Connecticut as a component of the National Wild and Scenic Rivers System.

The message further announced that the House disagrees to the amendments of the Senate to the bill (H.R. 4539) making appropriations for the Treasury Department, the U.S. Postal Service, the Executive Office of the President and certain independent agencies, for the fiscal year ending September 30, 1995, and for other purposes, and agrees to the conference asked by the Senate on the disagreeing votes of the two House thereon; and appoints Mr. HOYER, Mr. VISCLOSKY, Mr. DARDEN, Mr. OLVER, Mr. BEVILL, Mr. SABO, Mr. OBEY, Mr. LIGHTFOOT, Mr. WOLF, Mr. ISTOOK, and Mr. MCDADE as the managers of the conference on the part of the House.

The message also announced that the House agrees to the amendment of the Senate to the bill (H.R. 4812) to direct the Administrator of General Services to acquire by transfer the old U.S. Mint in San Francisco, CA, and for other purposes.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, which were referred as indicated:

EC-3216. A communication from the Administrator of the General Services Administration, transmitting, a draft of proposed legislation to require executive agencies to verify for correctness transportation charges prior to payment, and for other purposes; to the Committee on Governmental Affairs.

EC-3217. A communication from the Acting Director of the Office of Management and Budget, Executive Office of the President, transmitting, pursuant to law, the 1994 Federal Financial Management Status Report and Five-Year Plan; to the Committee on Governmental Affairs.

EC-3218. A communication from the Chairman of the Council of the District of Columbia, transmitting, pursuant to law, a copy of D.C. Act 10-323 adopted by the Council on June 21, 1994; to the Committee on Governmental Affairs.

EC-3219. A communication from the Secretary of Labor, transmitting, pursuant to law, the report of an evaluation of the pilot program of off-campus work authorization for foreign students; to the Committee on the Judiciary.

EC-3220. A communication from the Director of Communications and Legislative Affairs, Employment Opportunity Commission, transmitting, pursuant to law, the report of the Office of Program Operations for fiscal year 1993; to the Committee on Labor and Human Resources.

EC-3221. A communication from the Secretary of Labor, transmitting, pursuant to law, the annual report for fiscal year 1993; to the Committee on Labor and Human Resources.

EC-3222. A communication from the Comptroller General, transmitting, pursuant to law, the report of proposed and enacted rescissions through June 1, 1994; referred jointly, pursuant to law, to the Committee on Appropriations and to the Committee on the Budget.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second time by unanimous consent, and referred as indicated:

By Mr. BREAUX:

S. 2392. A bill to amend section 18 of the United States Housing Act of 1937, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

By Mr. DECONCINI (for himself and Mr. MCCAIN):

S. 2393. A bill to eliminate a maximum daily diversion restriction with respect to the pumping of certain water from Lake Powell, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. CAMPBELL:

S. 2394. A bill to establish a National Physical Fitness and Sports Foundation to carry out activities to support and supplement the mission of the President's Council on Physical Fitness and Sports; to the Committee on Labor and Human Resources.

By Mr. RIEGLE:

S. 2395. A bill to designate the United States Federal Building and Courthouse in Detroit, Michigan, as the "Theodore Levin Federal Building and Courthouse", and for other purposes; to the Committee on Environment and Public Works.

By Mr. LOTT:

S. 2396. A bill entitled the "Affordable Health Care Now Act"; read the first time.

By Mr. SHELBY (for himself and Mr. HEFLIN):

S. 2397. A bill to designate Building Number 137 of the Tuscaloosa Veterans' Medical Center in Tuscaloosa, Alabama, as the "Claude Harris, Jr. Building"; to the Committee on Veterans Affairs.

By Mr. SIMON (for himself and Ms. MOSELEY-BRAUN):

S. 2398. A bill to establish the Midewin National Tallgrass Prairie in the State of Illinois and for other purposes; to the Committee on Armed Services.

By Mr. EXON:

S. 2399. A bill to promote railroad safety and enhance interstate commerce; to the Committee on Commerce, Science, and Transportation.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. BREAUX:

S. 2392. A bill to amend section 18 of the United States Housing Act of 1937, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

PUBLIC HOUSING LEGISLATION

• Mr. BREAUX. Mr. President, today I am introducing a bill in the Senate that will promote the restoration and availability of affordable housing in this country in a cost-effective way. At the same time, it will protect the right of low-income tenants to affordable housing. A companion provision is included in the recently passed Housing

and Community Development Act of 1994, section 124, H.R. 3838, in the House of Representatives.

The objective of this bill is to build flexibility into any day-to-day applications of the so-called one-for-one-law. The essence of the rule is that for every demolished or otherwise disposed of public housing unit a new unit must be built. In practice, in an era of prolonged scarcity in Federal funding and changing urban housing demographics, this law forces the Housing and Urban Affairs Administration [HUD], to pour large sums of money into renovating run-down public housing projects when it would be less costly in many cases to tear them down and start over. That is the case at some public housing projects in New Orleans, LA.

As described in a July 25, 1994, New York Times article by Adam Nossiter, "Rule Pumps Dollars Into Decayed Housing," the impact of the rule at a housing project in New Orleans, LA, is repeated in housing projects around the country. The article relates particularly severe problems in Newark, Cleveland, and Washington, DC. Mr. President, I ask that the full text of this article, and that the entire bill be printed in the RECORD.

According to the Times, a renovation of one New Orleans project will cost $14 million more than costs of tearing it down. But you guessed it, Mr. President, work is already underway on plans to renovate that housing project at a cost of $90 to $100 million.

Under present law, HUD is handicapped if it finds that it is more cost-effective to tear-down public housing than renovate it in its entirety. Mr. President, a law that at one time may have been necessary to preserve public housing stock, makes less sense in circumstances such as those surrounding the Desire Public Housing Project in New Orleans. Three thousand people live in a project designed for 6,000 or more; and, as reported by the New York Times, the housing vacancy rate in New Orleans, at 16.6 percent, is the highest in the country.

Mr. President, there are other reasons why HUD should hesitate to pour large sums of Federal dollars into rebuilding some housing projects. Many projects were originally built as segregated colored housing. As described by the Times, "The Desire Housing Project in New Orleans is located 2 miles east of the French Quarter, and is cut off from the city by two sets of railroad tracks, the New Orleans Industrial Canal and acres of warehouses and factories. The irony of Desire is that its location is not a desirable area for any residential community. Moreover, there were 86 murders in the complex from 1989 to 1993, more than in any of the city's other housing projects in the same period, even though some of the others are larger."

Mr. President, the chairman of the Subcommittee on Housing in the House of Representatives, Representative COLLIN C. PETERSON, visited the Desire Project this year, and I commend his legislative efforts to make the one-for-one-law effective in today's circumstances. That legislation, which I am introducing in the Senate today, is a workable solution to a very serious problem.

This bill presents carefully developed procedures that will permit a public housing agency to apply to the Secretary of HUD for approval to demolish or dispose of all or parts of a federally assisted public housing project. At the same time, its provisions will protect an adequate supply of public and affordable housing for low-income Americans. Mr. President, it also protects the right of displaced tenants to assisted relocation to decent, safe, sanitary, and affordable housing. Moreover, any public housing agency's plan to demolish or otherwise dispose of public housing must be developed in consultation with tenants and tenant councils.

Mr. President, we need this important legislation, and I urge my colleagues to join me in sponsoring this bill.

I ask unanimous consent that the accompanying article and the full text of my bill be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S. 2392

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. DEMOLITION AND DISPOSITION OF PUBLIC HOUSING.

Section 18 of the United States Housing Act of 1937 (42 U.S.C. 1437p) is amended to read as follows:

"SEC. 18. DEMOLITION AND DISPOSITION OF PUBLIC HOUSING.

"(a) CONDITION OF HOUSING.—The Secretary may approve an application by a public housing agency for permission to demolish or dispose of a public housing project or a portion of a public housing project only if the Secretary has determined that—

"(1) in the case of—

"(A) an application proposing demolition of a public housing project or a portion of a public housing project, the project or portion of the project is obsolete as to physical condition, location, or other factors, and it is more cost effective to replace the project or portion of the project than to rehabilitate the project or portion of the project; or

"(B) an application proposing the demolition of only a portion of a project, the demolition will help to assure the remaining useful life of the remaining portion of the project;

"(2) in the case of an application proposing disposition of real property of a public housing agency by sale or other transfer—

"(A)(i) the property's retention is not in the best interests of the tenants or the public housing agency because—

"(I) developmental changes in the area surrounding the project adversely affect the health or safety of the tenants or the feasible operation of the project by the public housing agency;

"(II) disposition will allow the acquisition, development, or rehabilitation of other properties which will be more efficiently or effectively operated as low-income housing and which will preserve the total amount of low-income housing stock available in the community or housing sufficient to address the needs of the community as described in the comprehensive housing affordability strategy under section 105 of the Cranston-Gonzalez National Affordable Housing Act; or

"(III) because of other factors which the Secretary determines are consistent with the best interests of the tenants and public housing agency and which are not inconsistent with other provisions of this Act; and

"(ii) for property other than dwelling units, the property is excess to the needs of a project or the disposition is incidental to, or does not interfere with, continued operation of a project; and

"(B) the net proceeds of the disposition will be used for—

"(i) the payment of development costs for the replacement housing and for the retirement of outstanding obligations issued to finance original development or modernization of the project, which, in the case of scattered-site housing of a public housing agency, shall be in an amount that bears the same ratio to the total of such costs and obligations as the number of units disposed of bears to the total number of units of the project at the time of disposition; and

"(ii) to the extent that any proceeds remain after the application of proceeds in accordance with clause (i), the provision of housing assistance for low-income families through such measures as modernization of low-income housing, or the acquisition, development, or rehabilitation of other properties to operate as low-income housing; or

"(3) in the case of an application proposing demolition or disposition of any portion of a public housing project, assisted at any time under section 5(j)(2)—

"(A) such assistance has not been provided for the portion of the project to be demolished or disposed of during the 10-year period ending upon submission of the application; or

"(B) the property's retention is not in the best interest of the tenants or the public housing agency because of changes in the area surrounding the project or other circumstances of the project, as determined by the Secretary.

"(b) TENANT INVOLVEMENT AND REPLACEMENT HOUSING.—The Secretary may approve an application or furnish assistance under this section or under any other provision of this Act with respect to the demolition or disposition of public housing only if the following requirements are met:

"(1) TENANT CONSULTATION AND EMPLOYMENT.—The application submitted by the public housing agency—

"(A) has been developed in consultation with tenants and tenant councils, if any, who will be affected by the demolition or disposition;

"(B) includes a plan to employ public housing tenants in construction or rehabilitation, to the extent practicable, pursuant to section 3 of the Housing and Urban Development Act of 1968; and

"(C) contains a certification by appropriate local government officials that the proposed activity is consistent with the applicable comprehensive housing affordability strategy under section 105 of the Cranston-Gonzalez National Affordable Housing Act.

"(2) RELOCATION ASSISTANCE.—All tenants to be relocated as a result of the demolition or disposition will be provided assistance by the public housing agency and are relocated

to other decent, safe, sanitary, and affordable housing, which is, to the maximum extent practicable, housing of their choice, including housing assisted under section 8.

"(3) REPLACEMENT HOUSING.—The public housing agency has developed a plan that provides for additional decent, safe, sanitary, and affordable dwelling units for each public housing dwelling unit to be demolished or disposed of under such application or provides additional dwelling units sufficient to address the needs and demographic characteristics of the number of applicants on the waiting list of the agency equal to the number of units to be demolished or disposed of or the needs of the community, as described in the comprehensive housing affordability strategy under section 105 of the Cranston-Gonzalez National Affordable Housing Act, which plan—

"(A) provides for the provision of such additional dwelling units through—

"(i) the acquisition or development of additional public housing dwelling units, which may be units in housing owned (or leased for a period to be determined by the Secretary) by a partnership of a public housing agency and other entity in which the agency has a controlling interest;

"(ii) the use of 15-year project-based assistance under section 8;

"(iii) in the case of an application proposing demolition or disposition of 200 or more units, the use of tenant-based assistance under section 8 having a term of not less than 5 years;

"(iv) units acquired or otherwise provided for homeownership (including cooperative and condominium interests) by public housing residents under section 5(h), subtitle B or C of title IV of the Cranston-Gonzalez National Affordable Housing Act, or other programs for homeownership that have program requirements substantially equivalent to the requirements established under section 605 of the Housing and Community Development Act of 1987;

"(v) affordable housing homeownership units assisted under title II of the Cranston-Gonzalez National Affordable Housing Act and sold to public housing residents;

"(vi) rental units that are—

"(I) assisted under title II of the Cranston-Gonzalez National Affordable Housing Act (notwithstanding section 212(d)(2) of such Act); or

"(II) assisted under a State or local rental assistance program that provides for rental assistance over a term of not less than 15 years that is comparable in terms of eligibility and contribution to rent to assistance under section 8, except that this subclause shall only apply in cases provided under subparagraph (C);

"(vii) housing assisted by a tax credit under section 42 of the Internal Revenue Code of 1986;

"(viii) housing acquired from the Resolution Trust Corporation or the Federal Deposit Insurance Corporation;

"(ix) housing acquired under section 203 of the Housing and Community Development Amendments of 1978;

"(x) other methods of providing housing units approved by the Secretary; or

"(xi) any combination of such methods;

"(B) in the case of an application proposing demolition or disposition of 200 or more units, shall provide that—

"(i) not less than 50 percent of such additional dwelling units shall be provided through the acquisition or development of additional dwelling units or through project-based assistance; and

"(ii) not more than 50 percent of such additional dwelling units shall be provided through tenant-based assistance under section 8 having a term of not less than 5 years;

"(C) if it provides for the use of tenant-based assistance provided under section 8 or otherwise, may be approved—

"(i) only after a finding by the Secretary that replacement with project-based assistance is not feasible, and the supply of private rental housing actually available to those who would receive such assistance under the plan is sufficient for the total number of families in the community assisted with tenant-based assistance after implementation of the plan and that such supply is likely to remain available for the full term of the assistance; and

"(ii) only if such finding is based on objective information, which shall include rates of participation by owners in the section 8 program, size, conditions and rent levels of available rental housing as compared to section 8 standards, the supply of vacant existing housing meeting the section 8 housing quality standards with rents at or below the fair market rental, the number of eligible families waiting for public housing or housing assistance under section 8, and the extent of discrimination against the types of individuals or families to be served by the assistance;

"(D) may provide that all or part of such additional dwelling units may be located outside the jurisdiction of the public housing agency (in this subparagraph referred to as the 'original agency') if—

"(i) the location is in the same housing market area as the original agency, as determined by the Secretary; and

"(ii) the plan contains an agreement between the original agency and the public housing agency in the alternate location or other public or private entity that will be responsible for providing the additional units in the alternate location that such alternate agency or entity will, with respect to the dwelling units involved—

"(I) provide the dwelling units in accordance with subparagraph (A);

"(II) complete the plan on schedule in accordance with subparagraph (F);

"(III) meet the requirements of subparagraph (G) and the maximum rent provisions of subparagraph (H);

"(IV) not impose a local residency preference on any resident of the jurisdiction of the original agency for purposes of admission to any such units; and

"(V) allow that preference for admission to any such additional units may be provided to residents of the severely distressed public housing dwelling units replaced under this subparagraph pursuant to section 24;

"(E) includes a schedule for completing the plan during a period consistent with the size of the proposed demolition or disposition and replacement plan, which—

"(i) shall not exceed 6 years, except that the Secretary may extend the schedule to not more than 10 years if the Secretary determines that good cause exists to extend the implementation of the replacement plan under this subsection; and

"(ii) the demolition or disposition under the plan can occur in phases necessary to provide for relocation of tenants under paragraph (2);

"(F) includes a method of ensuring that the same number of individuals and families will be provided housing;

"(G) provides for the payment of the relocation expenses of each tenant to be displaced and ensures that the rent paid by the tenant following relocation will not exceed the amount permitted under this Act;

"(H) prevents the taking of any action to demolish or dispose of any unit until the tenant of the unit is relocated to decent, safe, sanitary, and affordable housing; and

"(I) permits the Secretary to intervene and take any actions necessary to complete the plan if the public housing agency fails, without good cause, to carry out its obligations under the plan.

"(c) LIMITATION ON DEMOLITION AND EXEMPTION.—

"(1) MAXIMUM PERCENTAGE.—Notwithstanding any other provision of this section, during any 5-year period a public housing agency may demolish not more than the lesser of 5 dwelling units or 5 percent of the total dwelling units owned and operated by the public housing agency, without providing an additional dwelling unit for each such public housing dwelling unit to be demolished, but only if the space occupied by the demolished unit is used for meeting the service or other needs of public housing residents.

"(2) SITE AND NEIGHBORHOOD STANDARDS EXEMPTION.—Notwithstanding any other provision of law, a replacement plan under subsection (b)(3) may provide for demolition of public housing units and replacement of such units on site or in the same neighborhood if the number of replacement units provided in the same neighborhood is fewer than the number of units demolished and the balance of replacement units are provided elsewhere in the jurisdiction or pursuant to subsection (b)(3)(D).

"(d) TREATMENT OF REPLACEMENT UNITS.—With respect to any dwelling units developed, acquired, or leased by a public housing agency pursuant to a replacement plan under subsection (b)(3)—

"(1) assistance may be provided under section 9 for such units; and

"(2) such units shall be available for occupancy, operated and managed in the manner required for public housing, and shall be subject to the other requirements applicable to public housing dwelling units.

"(e) APPROVAL OF APPLICATIONS.—

"(1) IN GENERAL.—The Secretary shall notify a public housing agency submitting an application under this section for demolition or disposition and replacement of a public housing project or portion of a project of the approval or disapproval of the application not later than 60 days after receiving the application. If the Secretary does not notify the public housing agency as required under this paragraph or paragraph (2), the application shall be considered to have been approved.

"(2) DISAPPROVAL AND RESUBMISSION.—If the Secretary disapproves an application, the Secretary shall specify in the notice of disapproval the reasons for the disapproval and the agency may resubmit the application as amended or modified.

"(3) ANNUAL REPORT.—The Secretary shall annually submit a report to the Congress describing for the year the applications under this section approved and disapproved, the number, general condition, and location of units demolished or disposed of, and the number, general condition, location, and method of provision of units of replacement housing provided pursuant to this section.

"(f) ACTION BEFORE APPROVAL OF APPLICATION.—

"(1) PROHIBITED ACTION.—A public housing agency shall not take any action to demolish or dispose of a public housing project or a portion of a public housing project without obtaining the approval of the Secretary and

satisfying the conditions specified in subsections (a) and (b).

"(2) ALLOWABLE RELOCATION.—A public housing agency may relocate tenants of public housing into other dwelling units before the approval of an application under this section for demolition or disposition, or prior to implementing a plan for modernization under section 14 or 24, if units to be demolished or disposed of are not decent, safe, and sanitary, or if the units to be rehabilitated cannot be maintained cost-effectively in a decent, safe, and sanitary condition.

"(g) ASSISTANCE FOR REPLACEMENT HOUSING.—The Secretary may provide assistance under this subsection for—

"(1) providing replacement public housing units pursuant to subsection (b)(3)(A) for units demolished or disposed of pursuant to this section; and

"(2) providing assistance under section 8 for replacement housing pursuant to subsection (b)(3)(A) for units demolished or disposed of pursuant to this section.

"(h) INAPPLICABILITY TO PUBLIC HOUSING HOMEOWNERSHIP PROGRAM.—The provisions of this section shall not apply to the disposition of a public housing project in accordance with an approved homeownership program under title III.

"(i) EXCEPTION TO REPLACEMENT RULE.—

"(1) REQUIREMENTS FOR WAIVER.—The Secretary shall waive the applicability of the provisions of subsection (b)(3) with respect to any application under this section by a public housing agency for the demolition or disposition of public housing dwelling units if—

"(A) the Secretary determines, based on information provided by the public housing agency in the application and the request under paragraph (2), that—

"(i) the requirements under subsection (b)(3) are preventing or interfering with the development or acquisition of new public housing dwelling units by the agency;

"(ii) the long-term goal of the agency in requesting the waiver under this subsection is to increase the number of habitable public housing dwelling units of the agency;

"(iii) maintaining and operating the dwelling units to be demolished or disposed of is not cost-effective; and

"(iv) sufficient financial assistance is not, and will not be, available to the public housing agency to rehabilitate or replace all or some of the units;

"(B) the Secretary determines that replacing the dwelling units to be demolished or disposed of under the application is unnecessary because other affordable housing is available in the area in which the units are located, and in making such determination the Secretary considers the assessment submitted by the public housing agency under paragraph (2)(C); and

"(C) the public housing agency requests a waiver under this subsection in accordance with the requirements of paragraph (2).

"(2) REQUEST FOR WAIVER.—To be eligible for a waiver under this subsection, a public housing agency shall submit to the Secretary a request for a waiver under this subsection that includes—

"(A) a comprehensive plan for demolition, disposition, and replacement that describes additional dwelling units to be made available by the public housing agency;

"(B) an identification of the dwelling units for which the waiver is requested; and

"(C) an assessment of the need of replacing such dwelling units including the unit size, age, general condition, and length of time such units have been vacant, the condition of the neighborhood in which the dwelling units are located, and the availability of dwelling units affordable to low-income families within the jurisdiction in which the dwelling units are located, during the implementation of the replacement plan.

"(3) SUBMISSION TO SECRETARY.—A request for a waiver under this subsection may be submitted at any time. The request shall be submitted to the Secretary by certified mail or any other equivalent means that provides notification to the public housing agency making the request of the date of receipt by the Secretary.

"(4) NOTICE OF DISPOSITION OF REQUEST.—Except as provided in paragraph (5), the Secretary shall notify a public housing agency requesting a waiver under this section of the approval or disapproval of the request not later than 45 days after receiving the request. If the Secretary does not notify the public housing agency as required under this paragraph or paragraph (5), the request for a waiver shall be considered to have been approved.

"(5) REQUEST FOR ADDITIONAL INFORMATION.—If the Secretary determines that more information is needed to make the determinations under paragraph (1) than has been provided by the public housing agency, the Secretary shall notify the agency in writing not later 30 days after receiving the request for the waiver that additional information is necessary. Such notice shall describe specifically the additional information required for the determinations and establish a deadline for the submission of the information by the agency, which shall be determined based on the difficulty of obtaining the information requested. If the agency submits such additional information requested before the deadline established in the notice under this paragraph, the Secretary shall notify the agency requesting the waiver that the request is approved or disapproved not later than 30 days after the submission of such additional information.

"(6) STATEMENT OF REASONS FOR DENYING OR APPROVING REQUEST.—The Secretary shall include, in each notice under paragraph (4) or (5) of the denial or approval of a request for a waiver under this subsection, the specific reasons for denying or approving the request. The denial of any request for a waiver for public housing dwelling units shall not prejudice the consideration of any other subsequent request for such a waiver for any of such dwelling units.".

RULE PUMPS DOLLARS INTO DECAYED HOUSING

(By Adam Nossiter)

NEW ORLEANS, July 25.—Roofless buildings yawning to the sky, gaping windows without glass, inside walls stripped to rough planks, outside walls pitted with holes: it isn't the emptiness of the Desire public housing development that is disconcerting, but the presence of any residents at all. About 3,000 people live in a project that was designed for more than twice that number.

In March, the Inspector General for the Department of Housing and Urban Development, Susan Gaffney, told Congress that renovating the isolated 97-acre reservation for the poor would cost $14 million more than tearing it down and starting over. Yet work is under way on a renovation plan that is expected to cost $90 million to $100 million. The housing agency has already approved the first $12 million.

The project, which is on the street immortalized by Tennessee Williams in his play "A Streetcar Named Desire," is a case study of what critics say is an irrationality of the Federal housing policy, one that has also affected cities like Newark, Cleveland and Washington. The root of the problem, the critics say, is a Federal housing agency policy that funnels large sums of money into decrepit apartments but provides little for new construction, and a law requiring that for every demolished apartment, a new unit be built, to keep the supply from dwindling.

This "one-for-one" law, as it is known, seems particularly irrational in New Orleans, which has the highest housing vacancy rate in the country, 16.6 percent, the Census Bureau says.

On Friday, the House overwhelmingly approved a bill that would revise the policy and ease the law. It would allow the demolition of the most decrepit public housing while freeing money designated for renovation to build new apartments. A housing bill is also before the Senate but it does not discuss the "one-for-one" law.

A leader in the drive for the House legislation was Representative Collin C. Peterson, Democrat of Minnesota, who toured Desire this year, and cited the project as an example of waste produced by the current policy. Mr. Peterson is the chairman of a House subcommittee on housing.

In the grim universe of decaying housing projects, Desire is "probably one of the worst in the country," a district inspector general for the housing agency, D. Michael Beard, said in a recent interview. Mr. Beard was in charge of an agency audit of the New Orleans Housing Authority completed last month.

The sprawling complex of two-story barracks-like buildings, built from 1953 to 1956, sits atop a landfill that was once a swamp. The ground is sinking beneath it, so that in many places porches have fallen away.

EXODUS BEGAN A DECADE AGO

Since the early 1980's, when Desire was almost full, residents have been moving out steadily as the project deteriorated and violence grew. The project is about 58 percent vacant. Of the 810 households there, 745 are headed by single women.

The project, two miles east of the French Quarter, is cut off from the rest of the city by two sets of railroad tracks, the New Orleans Industrial Canal and acres of warehouses and factories.

The complex was deliberately built of wooden frames, susceptible to the area's high humidity, as opposed to concrete and masonry, because the Federal Public Housing Administration, as it was known then, said it wanted to save money. It was built "as a colored project," according to the housing agency report completed last month, and only blacks still live there.

VIOLENCE AMID WRECKAGE

Today, some of the apartments look as if they have been pillaged by marauding armies. Remains of plaster walls lie heaped on rotting wood floors. Vandals have taken everything, down to the window frames and copper piping.

There were 86 murders in the complex from 1989 to 1993, more than in any of the city's other housing projects in the same period, even though some of the others are larger.

But even before the first tenants moved to Desire, a public housing tenants' association report called it a "waste of public money" and "unsafe for human habitation." Those words have echoed through the years and were heard yet again as the New Orleans Housing Authority considered the renovation.

In addition to the public housing laws, the pride of local housing officials and some of the tenants were behind the renovation.

"The neighborhood should exist," said Shelia Danzey, manager of the New Orleans Housing Authority. "It's like preservationists saying these 1832 houses should exist."

Ms. Danzey also questioned the credentials of the independent consulting concern that advised against rebuilding Desire, even though it is the same one hired by her agency in 1990. The concern, EA Technical Services Inc. of Atlanta, said renovating the project was neither "viable nor feasible."

The decision by the New Orleans housing authority to push the renovation plan was essential for getting it approved by Federal officials. Yet the Federal audit of the New Orleans agency called its operations "inefficient, ineffective and uneconomical."

Joseph Shuldiner, the Assistant Secretary for public and Indian housing, said of the renovation plan, "There are legitimate questions here, but in our judgment they didn't outweigh the official policy of going along with the local request."

$12 MILLION COMMITMENT

In the first phase of the renovation, about $12 million has been awarded to the Rex K. Johnson Company, a Lampasas, Tex., concern that specialized in public housing work, to rebuild about 180 apartments. They have been redesigned as town houses, with each apartment having its own access to the street.

The overall plan calls for spending $71,000 to $78,000 for each apartment, which exceeds the housing agency's own spending limit for a new apartment by as much as 37 percent. The amount being spent to renovate each apartment could buy comfortable three-bedroom dwellings in many parts of New Orleans.

Under the renovation plan, a third of Desire's 1,800 apartments would be demolished and the rest would be gutted and rebuilt. The tenants would remain during the renovation. To conform to the one-for-one rule, for each Desire apartment demolished the housing authority will subsidize the rents for the same number of apartments.

LAW BEHIND THE REBUILDING

In 1987, the tide had long since turned against construction of big public housing projects when Congress mandated that every housing unit torn down had to be replaced with a new one. In practice, the rule forced local authorities to leave deteriorating housing projects standing.

In addition to limiting money for new constructions, the housing rules bar new developments in areas that already have large poor and minority populations. Neighborhood opposition to new public housing is often intense.

For the current fiscal year, Congress appropriated $559 million for new housing against $3.2 billion for renovation. It also appropriated $7 billion for rental vouchers to be used for private housing. But there are limits on the number of vouchers that can be used to replace housing that has been demolished.

The national landscape is littered with decaying, empty housing projects. Newark has long wanted to demolish 21 high-rise apartments. The one-for-one rule made this difficult, so the city's housing authority received $17 million in Federal housing operation subsidies for closed and sealed buildings from 1985 to 1992, enabling the authority to accumulate reserves of $31 million and "become financially sound," in Inspector General Gaffney's words.

The Cuyahoga Housing Authority in Cleveland has received $47.3 million in operating subsidies for vacant units since 1987, and the Washington authority $5.5 million in 1992.

These accounts of subsidies for empty apartments, recited in March before Mr. Peterson's subcommittee, led to the legislation passed on Friday. It would allow all local housing officials to sue up to half their renovation money for new housing. It would also allow them to ask the Federal housing agency to waive the rule requiring one new housing unit for each one demolished if it interfered with the development of new public housing.

An amendment to the bill would also allow New Orleans housing officials to use money designated for the renovation of the Desire in other ways, including renovating some of the city's many vacant dwellings for housing the Desire tenants.

The new Mayor of New Orleans, Marc Morial, who inherited the Desire renovation plan, says he supports the amendment that would give the city more discretion with its Federal housing money. He suggested that some of the $100 million may be better spent repairing the city's many abandoned houses, some of them with distinctive Creole architectural features still intact. But he said he wanted the first phase of the Desire renovation to be completed.

At Desire, there is suspicion of politicians, anger about the conditions and, in some residents, no interest at all in moving somewhere else. Charlene Slack, for one is glad to see the construction crews. "I'm happy about it," she said. "But I wish they would hurry up."

Bonnie Rodgers, vice chairman of the tenant council, said: "Don't send us somewhere else. Let us change where we live."

But others don't see much hope in change. Penny Jones stood by the rotting wood of her kitchen floor, near the bathroom where the sink was coming off the wall, and by the stairwell that looked like an elongated piece of Swiss cheese.

"I think they should tear it all down," she said. The summer heat, had aggravated the stink of the sewage beneath her building, she said. Indeed; the Atlanta consulting firm found that the "subsidence of the soil has caused continuous problems with the sewer and water systems."

There were a "million" mice in the apartment. "They need to just tear it all down and start from scratch," Ms. Jones said. "They can fix it up. I don't care. I'm going to move."•

By Mr. DECONCINI (for himself and Mr. MCCAIN):

S. 2393. A bill to eliminate a maximum daily diversion restriction with respect to the pumping of certain water from Lake Powell, and for other purposes; to the Committee on Energy and Natural Resources.

LAKE POWELL DIVERSION RESTRICTION ACT OF 1994

• Mr. DECONCINI. Mr. President, I am today introducing a bill that removes a maximum daily water diversion restriction imposed upon the city of Page, AZ, by the Reclamation Development Act of 1974. Although the bill removes the daily pumping limitation, it retains the limit on the city of Page's annual consumption amount.

I am very pleased that the bill is being cosponsored by my colleague from Arizona, Senator MCCAIN.

The city of Page receives its water solely from the Colorado River that is impounded within Lake Powell. Lake Powell is impounded behind the Glen Canyon Dam which was constructed by the Bureau of Reclamation.

The 1974 Reclamation Development Act severed the Federal Government's ownership and management of an area within the Colorado River project in Coconino County, AZ, creating a self-governing city. That city, Page, AZ, required water to survive in the desert environment. The 1974 legislation ensures that Page's water need is met by providing for an annual supply of water with a daily pumping limitation.

For a number of years after this legislation was authorized, the Bureau of Reclamation had varying degrees of responsibility and liability for operation and maintenance of the municipal water system. As the Bureau's authority was phased out, the city became responsible for all costs for the operation, maintenance, and replacement of the municipal water system beyond Glen Canyon Dam and the powerplant.

The city is concerned that they may need to exceed the daily pumping limitation during peak use periods in the summer months. As the city's population grows and national park tourism increases, this daily pumping limit will place an unrealistic burden on Page, especially during the summer season.

I urge my colleagues to give this bill serious consideration. I have been advised that the removal of this daily pumping limitation will not affect any other water users. I ask unanimous consent that the text of the bill and a letter from the Bureau of Reclamation be included in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S. 2393

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. ELIMINATION OF 24-HOUR RESTRICTION.

The second sentence of section 104(c) of the Reclamation Development Act of 1974 (Public Law 93-493; 88 Stat. 1488) is amended by striking "or three million gallons of water in any twenty-four hour period,".

U.S. DEPARTMENT OF THE INTERIOR,
BUREAU OF RECLAMATION,
Salt Lake City, UT, August 12, 1994.

Hon. DENNIS DECONCINI,
U.S. Senate,
Washington DC.

DEAR SENATOR DECONCINI: Officials in Washington, D.C. reviewed the proposal with Mayor Scaramazzo of the City of Page (Page), Arizona, to eliminate the daily pumping limitation of 3,000,000 gallons per day from Lake Powell for the City of Page, Arizona imposed by subsection 104(c) of the Reclamation Development Act of October 27, 1974, (P.L. 93-493). Mayor Scaramazzo was informed that since the maximum annual depletion of 2,740 acre-feet reserved to Page will not change under the proposal, the concept does not appear to adversely affect any other user of the Colorado River, and Arizona's use of 50,000 acre-feet of annual depletion under the Upper Colorado River Basin

Compact is unaffected. We have no objection to this concept.

We have reviewed the draft Bill language and it appears to match the proposed concept. However, our review should not be construed to reflect the Administration's position on the final Bill when sent to Congress.

Sincerely,

RICK L. GOLD
(For Charles A. Calhoun, Regional Director).•

• Mr. MCCAIN. Mr. President, I am in full support of the measure being introduced by my colleague from Arizona. The problem affecting the city of Page is a simple one, as is the measure we have introduced to correct it. The bill would remove the daily pumping limitation without affecting the city's overall allocation.

As my colleague noted, the city's sole source of water is a Colorado River allocation through Lake Powell. The city's enabling legislation limits the daily pumping rate from Lake Powell to 3 million gallons per day.

It is my understanding that the limitation was applied because of limitations on the Bureau of Reclamation's ability to pump at the time of enactment. However, that rationale no longer applies because the city is now responsible for both the pumping equipment and the cost of pumping water from the lake to the city.

The amendment would merely remove the daily pumping limit from the enabling legislation without affecting the city's overall allocation of Colorado River water. This is a very important point.

The Colorado River is the life blood to many communities along its path. Although it is clear that the bill will not affect other Colorado River users, we must ensure that the appropriate users are contacted and consulted. Especially, the Navajo Nation which has a significant interest in Colorado River water. Since the river is such an important resource, decisions affecting its management, even minor ones, should be discussed in an open process. I am confident that this bill is something all parties will support.

I hope my colleagues will give this measure serious consideration and that we can enact it quickly. While it is a minor change, it is one that is very important to the city of Page and its residents who depend on this vital source of water.•

By Mr. CAMPBELL:

S. 2394. A bill to establish a National Physical Fitness and Sports Foundation to carry out activities to support and supplement the mission of the President's Council on Physical Fitness and Sports; to the Committee on Labor and Human Resources.

NATIONAL PHYSICAL FITNESS AND SPORTS FOUNDATION ACT

• Mr. CAMPBELL. Mr. President, I am introducing legislation to establish a National Physical Fitness and Sports Foundation bill. This proposal is designed to support the President's Council on Physical Fitness.

The President's Council on Physical Fitness currently operates on a shoestring budget of $1.4 million. The establishment of a non-profit foundation would permit the Council to have an independent source of funding to expand its scope and activities. This proposal will not conflict with existing efforts to provide funding for the U.S. Olympic Committee as moneys that would flow through the corporation to the Council would not be public funds.

Once established, the National Physical Fitness and Sports Foundation would be a charitable, non-profit organization designed to encourage and promote the solicitation of private funds for the President's Council on Physical Fitness. After the deduction of administrative expenses, the foundation would annually transfer the balance of the contributions to the U.S. Public Health Service Gift Fund.

The foundation would have the following specific powers:

It could accept, receive, solicit, administer, and use any gift, devise or bequest, absolutely or in trust.

It could acquire by purchase or exchange any real or personal property or interest; and

It could enter into contracts or other arrangements with public agencies and private organizations and persons and to make such payments as may be necessary to carry out its functions.

A nine-member board of directors would govern the foundation. Three board members must have experience directly related to physical fitness, sports or the relationship between health status and physical exercise. The remaining six board members would be leaders in the private sector with a strong interest in physical fitness. Ex officio members of the board would include the Assistant Secretary of Health, the Executive Director of the President's Council on Physical Fitness, the Director of the National Center for Chronic Disease Prevention and Health Promotion, the Director of the National Heart, Lung and Blood Institute, and the Director of the Centers for Disease Control.

Board members would serve for 6 years. Three board members would be appointed by the Secretary of Health and Human Services; two by the majority leader of the Senate; one by the minority leader of the Senate; two by the Speaker of the House; and one by the minority leader of the House of Representatives. The chairman would be elected by the board members to a 2-year term. No individual could serve more than two consecutive terms as a director.

Board members would serve without pay, but would be reimbursed for traveling and subsistence expenses. The board would be empowered to appoint officers and employees, once the foundation had sufficient funding to pay for their services; and adopt a constitution and bylaws. Officers and employees of the foundation could not receive pay in excess of the annual rate of basic pay in effect for Executive Level V in the Federal service.

I think that this bill will help further an important national goal—encouraging and fostering physical fitness and well-being—and I urge my colleagues to support it.

Mr. President, I also ask unanimous consent that a complete copy of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 2394

Be it enacted by the Senate and the House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "National Physical Fitness and Sports Foundation Establishment Act".

SEC. 2. ESTABLISHMENT AND PURPOSE OF FOUNDATION.

(a) ESTABLISHMENT.—There is established the National Physical Fitness and Sports Foundation (hereinafter in this Act referred to as the "Foundation"). The Foundation is a charitable and nonprofit corporation and is not an agency or establishment of the United States.

(b) PURPOSES.—The purposes of the Foundation are—(1) in conjunction with the President's Council on Physical Fitness and Sports, to develop a list and description of programs, events and other activities which would further the goals outlined in Executive Order 12345 and with respect to which combined private and governmental efforts would be beneficial.

(2) to encourage and promote the participation by private organizations in the activities referred to in subsection (b)(1) and to encourage and promote private of money and other property to support those activities.

(c) DISPOSITION OF MONEY AND PROPERTY.—At least annually the Foundation shall transfer, after the deduction of the administrative expenses of the Foundation, the balance of any contributions received for the activities referred to in subsection (b), to the United States Public Health Service Gift Fund pursuant to section 2701 of the Public Health Service Act (42 U.S.C.-300aaa) for expenditure pursuant to the provisions of that section and consistent with the purposes for which the funds were donated.

SEC. 3. BOARD OF DIRECTORS OF THE FOUNDATION.

(a) ESTABLISHMENT AND MEMBERSHIP.—The Foundation shall have a governing Board of Directors (hereinafter referred to in this Act as the "Board"), which shall consist of nine Directors each of whom shall be a United States citizen; and

(1) Three of whom must be knowledgeable or experienced in one or more fields directly connected with physical fitness, sports or the relationship between health status and physical exercise;

(2) Six of whom must be leaders in the private sector with a strong interest in physical fitness, sports or the relationship between health status and physical exercise. The membership of the Board, to the extent practicable, shall represent diverse professional

specialities relating to the achievement of physical fitness through regular participation in programs of exercise, sports and similar activities. The Assistant Secretary for Health, the Executive Director of the President's Council on Physical Fitness and Sports, the Director for the National Center for Chronic Disease Prevention and Health Promotion, the Director of the National Heart, Lung, and Blood Institute and the Director for the Centers for Disease Control and Prevention shall be ex officio, nonvoting members of the Board. Appointment to the Board or its staff shall not constitute employment by, or the holding of an office of, the United States for the Purpose of any Federal employment or other law.

(b) APPOINTMENT AND TERMS.—Within 90 days from the date of enactment of this Act, the Directors of the Board will be appointed. The Directors shall serve for a term of six years; three of whom will be appointed by the Secretary (hereinafter referred to in this Act as the "Secretary"); two by the Majority Leader of the Senate; one by the Minority Leader of the Senate; two by the Speaker of the House of Representatives; one by the Minority Leader of the House of Representatives. A vacancy on the Board shall be filled within sixty days of said vacancy in the manner in which the original appointment was made, and shall be for the balance of the term of the individual who was replaced. No individual may serve more than two consecutive terms as a Director.

(c) CHAIRMAN.—The Chairman shall be elected by the Board from its members for a two-year term and will not be limited in terms or service.

(d) QUORUM.—A majority of the current membership of the Board shall constitute a quorum for the transaction of business.

(e) MEETINGS.—The Board shall meet at the call of the Chairman at least once a year. If a Director misses three consecutive regularly scheduled meetings, that individual may be removed from the Board and the vacancy filled in accordance with subsection 3(b).

(f) REIMBURSEMENT OF EXPENSES.—Members of the Board shall serve without pay, but may be reimbursed for the actual and necessary traveling and subsistence expenses incurred by them in the performance of the duties of the Foundation, subject to the same limitations on reimbursement that are impose upon employees of Federal agencies.

(g) GENERAL POWERS.—(1) The Board may complete the organization of the Foundation by—

(A) appointing officers and employees;

(B) adopting a constitution and bylaws consistent with the purposes of the Foundation and the provision of this Act. In establishing bylaws under this subsection, the Board shall provide for policies with regard to financial conflicts of interest and ethical standards for the acceptance, solicitation and disposition of donations and grants to the Foundation; and

(C) undertaking such other acts as may be necessary to carry out the provisions of this Act.

(2) The following limitations apply with respect to the appointment of officers and employees of the Foundation:

(A) Officers and employees may not be appointed until the Foundation has sufficient funds to pay them for their service. No individual so appointed may receive pay in excess of the annual rate of basic pay in effect for Executive Level V in the Federal service.

(B) The first officer or employee appointed by the Board shall be the Secretary of the Board who (i) shall serve, at the direction of the Board, as its chief operating officer, and (ii) shall be knowledgeable and experienced in matters relating to physical fitness and sports.

(C) No Public Health Service employee nor the spouse or dependent relative of such an employee may serve as an officer or member of the Board of Directors or as an employee of the Foundation.

(D) Any individual who is an officer, employee, or member of the Board of the Foundation may not (in accordance with the policies developed under subsection 3(g)(1)(B)) personally or substantially participate in the consideration or determination by the Foundation of any matter that would directly or predictably affect any financial interest of the individual or a relative (as such term is defined in section 109 (16) of the Ethics in Government Act of 1978) of the individual, of any business organization or other entity, or of which the individual is an officer or employee, or is negotiating for employment, or in which the individual has any other financial interest.

SEC. 4. RIGHTS AND OBLIGATIONS OF THE FOUNDATION.

(a) IN GENERAL.—The Foundation—

(1) shall have perpetual succession;

(2) may conduct business throughout the several State, territories, and possessions of the United States;

(3) shall have its principal offices in or near the District of Columbia; and

(4) shall at all times maintain a designated agent authorized to accept service of process for the Foundation. The serving of notice to, or service of process upon, the agent required under paragraph 4(a)(4), or sailed to the business address of such agent, shall be deemed as service upon or notice to the Foundation.

(b) SEAL.—The Foundation shall have an official seal selected by the Board which shall be judicially noticed.

(c) POWERS.—To carry out its purposes under section 2, and subject to the specific provisions thereof, The Foundation shall have the usual powers of a corporation acting as a trustee in the District of Columbia, including the power—

(1) except as otherwise provided herein, to accept, receive, solicit, hold, administer and use any gift, devise, or bequest, either absolutely or in trust, of real or personal property or any income therefrom or other interest therein;

(2) to acquire by purchase or exchange any real or personal property or interest therein;

(3) unless otherwise required by the instrument of transfer, to sell, donate, lease, invest, reinvest, retain or otherwise dispose of any property or income therefrom.

(4) to sue and be sued, and complain and defend itself in any court of competent jurisdiction, except for gross negligence;

(5) to enter into contracts or other arrangements with public agencies and private organizations and persons and to make such payments as may be necessary to carry out its functions; and

(6) to do any and all acts necessary and proper to carry out the purposes of the Foundation.

(d) DEFINITIONS.—For purposes of this Act, an interest in real property shall be treated as including, among other things, easements or other rights for preservation, conservation, protection, or enhancement by and for the public of natural, scenic, historic, scientific, educational, inspirational or recreational resources. A gift, devise, or bequest may be accepted by the Foundation even though it is encumbered, restricted or subject to beneficial interests of private persons if any current or future interest therein is for the benefit of the Foundation.

SEC. 5. VOLUNTEER STATUS.

The Foundation may accept, without regard to the civil service classification laws, rules, or regulations, the services of volunteers in the performance of the functions authorized herein, in the manner provided for under section 7(c) of the Fish and Wildlife Act of 1956 (16 U.S.C. 742f(c)).

SEC. 6. AUDIT, REPORTING REQUIREMENTS AND PETITION TO ATTORNEY GENERAL FOR EQUITABLE RELIEF.

(a) AUDITS.—For purposes of the act entitled "An Act for audit of accounts of private corporations established under Federal law", approved August 30, 1964 (Public Law 88–504, 36 U.S.C. 1101–1103, the Foundation shall be treated as a private corporation under Federal law. The Inspector General of the Department of Health and Human Services and the Comptroller General of the United States shall have access to the financial and other records of the Foundation, upon reasonable notice.

(b) REPORT.—The Foundation shall, as soon as practicable after the end of each fiscal year, transmit to the Secretary of the Department of Health and Human Services and to Congress a report of its proceedings and activities during such year, including a full and complete statement of its receipts, expenditures, and investments.

(c) RELIEF WITH RESPECT TO CERTAIN FOUNDATION ACTS OR FAILURE TO ACT.—If the Foundation:

(1) engages in, or threatens to engage in, any act, practice or policy that is inconsistent with its purposes set forth in section 2(b); or

(2) refuses, fails, or neglects to discharge its obligations under this Act, or threaten to do so; the Attorney General of the United States may petition in the United States District Court for the District of Columbia for such equitable relief as may be necessary or appropriate.

SEC. 7. AUTHORIZATION OF APPROPRIATIONS.

There are hereby authorized such sums as are necessary to carry out the purposes of this Act, Provided that, such sums are only available to the Foundation for organizational costs.●

By Mr. RIEGLE:

S. 2395. A bill to designate the United States Federal Building and Courthouse in Detroit, Michigan, as the "Theodore Levin Federal Building and Courthouse," and for other purposes; to the Committee on Environment and Public Works.

THE THEODORE LEVIN FEDERAL BUILDING AND COURTHOUSE ACT OF 1994

● Mr. RIEGLE. Mr. President, I introduce legislation which officially designates the U.S. Federal Building and Courthouse in Detroit, Michigan, as the "Theodore Levin Federal Building and Courthouse."

Theodore Levin was a man of high morals and exemplary dedication. Born in Chicago in February 1897, he received a bachelor of law degree from the University of Detroit in 1920 and was admitted to the bar.

In the years that followed, Theodore Levin worked to preserve the integrity of the law through his numerous public appointments. In 1933, he was selected

to serve as special assistant attorney general of Michigan to conduct grand jury proceedings relating to the closing of Michigan banks. During the Second World War, he was a member of the State Selective Service Appeals Board. And, in July 1946, President Harry Truman nominated Theodore Levin to the U.S. District Court for the Eastern District of Michigan.

Theodore Levin served the bench with fortitude, distinction, and honor. He was recognized and respected for the effort he made to ensure unbiased sentencing practices. Adamantly opposed to the disparity he saw in sentences given for similar crimes, he developed sentencing councils in the Eastern District of Michigan and encouraged groups of judges to join. These councils contributed greatly to achieving equity in sentencing.

Throughout his life, Theodore Levin was committed to the good and welfare of the community. He offered leadership to the people of Detroit in his service at the Detroit Community Fund, the Council of Social Agencies, the Big Brother Conference, the United Health and Welfare Fund of Michigan, and the Detroit Round Table of Catholics, Jews, and Protestants. He served as a member of the board and as president for the United Jewish Charities of Detroit, was chairman of the executive committee and president of the Jewish Welfare Federation of Detroit. Further, he was an active member of the board of trustees of the Jewish Publication Society of America, and served on the board of the National Council of Jewish Federations.

Theodore Levin's service was honored in 1961 with a doctor of laws degree from Wayne State University, and, in 1970, he was awarded a doctorate of humane letters by Hebrew Union College.

In 1925, he married Rhoda Katzin and together they had three sons a daughter. Theodore Levin was a noble man who, until his death in 1970, devoted his life to his family and to his work.

Mr. President, I am pleased to introduce this bill today honoring this remarkable man and his life. I urge my colleagues to join me in paying tribute to Theodore Levin by moving promptly to enact this bill, officially naming Detroit's Federal building and courthouse after him.●

By Mr. SHELBY (for himself and Mr. HEFLIN):

S. 2397. A bill to designate Building No. 137 of the Tuscaloosa Veterans' Medical Center in Tuscaloosa, AL, as the "Claude Harris, Jr. Building"; to the Committee on Veterans' Affairs.

THE CLAUDE HARRIS, JR. BUILDING ACT OF 1994

● Mr. SHELBY. Mr. President, I introduce legislation that designates building No. 137 which will soon be completed at the Tuscaloosa Veterans' Medical Center in Tuscaloosa, AL as the Claude Harris, Jr. Building. I am jointed by the senior Senator from Alabama.

My good friend and colleague Claude Harris, who is currently the U.S. attorney for the Northern District of Alabama, represented the people of the Seventh District of Alabama for three terms in the House of Representatives. While in the House, Representative Harris served with eminent distinction on the Committee on Veterans' Affairs and became an expert on issues that affect both veterans and the Armed Forces.

Mr. President, I had the pleasure to serve the people of the Seventh Congressional District for four terms before being elected to the Senate. I was also a member of the Committee on Veterans' Affairs and can truly appreciate all that Claude Harris accomplished for veterans in Alabama and across America. Claude, who has risen to the rank of colonel in the Alabama National Guard, is a true friend of all veterans and richly deserves this honor.●

By Mr. EXON:

S. 2399. A bill to promote railroad safety and enhance interstate commerce; to the Committee on Commerce, Science, and Transportation.

RAILROAD GRADE CROSSING SAFETY ACT OF 1994

● Mr. EXON. Mr. President, I am pleased to introduce the Railroad Grade Crossing Safety and Research Act of 1994.

Most deaths and injuries which occur in the rail industry are as a result of trespassers and motorist violation of railroad grade crossing laws. About 600 people a year die as a result of railroad crossing accidents and about 600 people a year die as a result of trespassing on railroad property.

An automobile and a train collide once about every 90 minutes in the United States. In 1992 approximately 2,500 people were either killed or seriously injured as a result of railroad grade crossing accidents.

This is one area of death and injury which is preventable. The bill I introduce today is meant to complement the rail safety legislation I introduced at the administration's request earlier this year. I intend to recommend that the Senate Commerce Committee approve this legislation, the Rail Safety Act and rail crossing legislation introduced by Senator DANFORTH earlier this year as a single comprehensive rail safety initiative.

The legislation I introduce today is in response to surface transportation hearings I chaired earlier this year. Those hearings indicated that although significant progress has been made in reducing the number of rail-related deaths, there is still room for improvement, especially when it comes to grade crossing safety.

States and local governments must be encouraged to enforce their laws against grade crossing violations and must be encouraged to finally close crossings. The split jurisdiction between the Federal Highway Administration, the Federal Rail Administration, States, local governments, and railroads has led to a gridlock of responsibility. This legislation, particularly when combined with the two bills I mentioned earlier and the administration's grade crossing safety initiative currently before the Senate Public Works Committee will shatter that gridlock.

It is time to make the places where rails meet roads safer for rail workers, drivers, pedestrians, and industry. The legislation I introduce today has that goal in mind.

Mr. President, these are the highlights of the Railroad Grade Crossing Safety and Research Act. This important legislation: First, establishes an Institute for Railroad and Grade Crossing Safety to research, study, and test improvements in railroad and grade crossing safety devices. There is no clear procedure to test the effectiveness of new crossing devices. The Institute will research, develop, fund, and test measures for reducing the number of fatalities and injuries in rail operations and focus on railroad grade crossing improvements, trespassing prevention and enforcement;

Second, requires the Secretary to coordinate a trespassing and vandalism prevention strategy with Federal, State and local governments as well as the private sector;

Third, establishes a maximum $5,000 civil penalty for vandalizing a railroad grade crossing device, a maximum $2,500 penalty for trespassing on railroad right-of-way, and encourages the railroads to warn the public of potential liability to deter illegal and dangerous acts;

Fourth, provides for the establishment of a toll-free 800 number for the public to report crossing malfunctions;

Fifth, prohibits local whistle bans unless certain grade crossing improvements or actions have been taken;

Sixth, requires the Secretary of Transportation to initiate a rulemaking on rail car visibility;

Seventh, makes grade crossing safety, trespass prevention, and vandalism prevention Department of Transportation research priorities; and

Eighth, establishes a statewide crossing freeze combined with a trade-in program where States are required to trade in up to three old crossings for every new crossing built after the effective date of the regulations required by this legislation.

I encourage my colleagues to review this legislation and welcome their support.

Mr. President, I ask unanimous consent that the text of the Railroad Grade Crossing Safety and Research Act be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 2399

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Railroad Grade Crossing Safety and Research Act of 1994".

SEC. 2. INSTITUTE FOR RAILROAD AND GRADE CROSSING SAFETY.

The Secretary of Transportation (hereinafter Secretary), in conjunction with a university or college having expertise in highway driver and railroad safety, shall establish within one year of enactment of this Act, an Institute for Railroad and Grade Crossing Safety (hereinafter Institute). The Institute shall research, develop, fund, or test measures for reducing the number of fatalities and injuries in rail operations. The Institute shall focus on improvements in railroad grade crossing safety, railroad trespass prevention, prevention of railroad vandalism, and the improved enforcement of laws in such areas. There is hereby authorized to be appropriated an additional $1,000,000 for each of the fiscal years 1996 through 2000 for the Institute, which will make periodic reports to the Secretary of Transportation and the Congress.

SEC. 3. RAILROAD GRADE CROSSING, TRESPASSING AND VANDALISM PREVENTION STRATEGY.

(a) Not later than one year after the date of enactment of this Act, and in consultation with affected parties, the Secretary shall evaluate and review current local, State, and Federal codes regarding trespass on railroad property and vandalism affecting railroad safety and develop model prevention and enforcement codes and enforcement strategies for the consideration of State and local legislatures and governmental entities.

(b) Within one year of enactment of this Act, the Secretary shall develop and maintain a comprehensive outreach program to improve communications among Federal railroad safety inspectors, Federal Rail Administration-certified State inspectors, railroad police, and State and local law enforcement, for the purpose of addressing trespass and vandalism dangers on railroad property, and strengthening relevant law enforcement strategies. This program shall increase public and police awareness of the legality of, dangers inherent in, and the extent of, trespassing on railroad right-of-way, to develop strategies to improve the prevention of trespass and vandalism, and to improve the enforcement of laws relating to railroad trespsss, vandalism, and grade crossing safety.

(c) For purposes of this Act, a trespasser is defined as a person who is on that part of railroad property used in railroad operations and whose presence is prohibited, forbidden or unlawful.

SEC. 4. CIVIL PENALTY FOR VANDALISM.

Not later than six months after the date of enactment of this Act, the Secretary shall amend the Secretary's regulations under section 202 of the Federal Railroad Safety Act of 1970 (45 U.S.C. 431) to make subject to a civil penalty of up to $5,000 under such Act any person who defaces, disables, damages, vandalizes or commits any act that adversely affects the function of any railroad grade crossing related signal system, sign, gate, device, sensor, or equipment.

SEC. 5. CIVIL PENALTY FOR TRESPASS ON RAILROAD PROPERTY.

Not later than six months after the date of enactment of this Act, the Secretary of Transportation shall amend the Secretary's regulations under section 202 of the Federal Railroad Safety Act of 1970 (45 U.S.C. 431) to make subject to a civil penalty of up to $2,500 under such an Act any person who trespasses on a railroad owned or railroad leased right-of-way, road, or bridge.

SEC. 6. WARNING OF CIVIL LIABILITY.

The Secretary shall permit and encourage railroads to warn the public about potential Federal civil liability for violations of Federal regulations related to vandalism of railroad crossing related devices, signs, and equipment and trespass on railroad property.

SEC. 7. WHISTLE BAN PROHIBITION.

Upon the date of enactment, no State or political subdivision thereof shall impose a whistle ban with respect to any railroad grade crossing or series of railroad grade crossings unless one of the following actions has been taken:

(a) The affected crossing is closed during the pendency of the ban;

(b) Crossing gates and median barriers have been installed and are operational at the affected crossing;

(c) Four quadrant gates have been installed and are in operation at the affected crossing;

(d) An automated horn system crossing device has been installed; or

(e) The Federal Rail Administrator has granted specific, time-limited permission for such ban.

SEC. 8. RAIL CAR VISIBILITY.

(a) The Secretary shall conduct a review of the Department of Transportation's rules with respect to rail car visibility. As part of this review, the Secretary shall collect relevant data from operational experience of railroads having enhanced visibility measures in service.

(b) Not later than June 30, 1996, the Secretary shall initiate a rulemaking proceeding to issue regulations requiring substantially enhanced visibility standards for newly manufactured and remanufactured rail cars. In such rulemaking proceedings the Secretary shall consider at a minimum—

(1) visibility from the perspective of automobile drivers;

(2) whether certain rail car paint colors should be prohibited or required;

(3) the use of reflective materials;

(4) the visibility of lettering on rail cars;

(5) the effect of any enhanced visibility measures on the health and safety of train crew members; and

(6) the ratio of cost to benefit of any new regulations.

(c) In issuing regulations under paragraph (b), the Secretary may exclude from any specific visibility requirement any category of trains or rail operations if the Secretary determines that such an exclusion is in the public interest and is consistent with rail safety including railroad grade crossing safety.

(d) As used in this subsection, the term "railcar visibility" means the enhancement of driver, pedestrian, and railroad worker ability to observe trains consistent with public safety with particular consideration of enhancing safety at railroad grade crossings.

SEC. 9. STATEWIDE RAILROAD GRADE CROSSING FREEZE.

Not later than two years after the date of enactment of this Act, the Secretary shall initiate a rulemaking proceeding to issue regulations which:

(a) impose a freeze on the total number of railroad grade crossings in each State of the United States of America;

(b) after the effective date of the regulation require any new railroad grade crossing opening to receive the specific approval of the Federal Rail Administrator;

(c) require that unless otherwise in the public interest, or necessary to facilitate interstate commerce, three existing railroad grade crossings be closed in the requesting State for each new railroad grade crossing opened after the effective date of this regulation.

(d) permit the Federal Rail Administrator to waive the application of this regulation once a State has achieved significant and sufficient reductions in the total number railroad grade crossings or has an optimal number of railroad grade crossings for the entire State.

SEC. 10. RESEARCH PRIORITIES.

The Secretary of Transportation shall incorporate the enhancement of railroad grade crossing safety, the prevention of trespassing on railroad property, and the prevention of vandalism to railroad grade crossing safety devices, signs, and equipment into the research, technology development, and testing priorities of the Department of Transportation. In carrying out activities authorized by this Act, the Secretary shall consult with such other governmental agencies concerning the availability and affordability of appropriate technologies, especially defense related technologies for application to railroad crossing safety, trespass and vandalism prevention and other rail safety initiatives.

SEC. 11. EMERGENCY NOTIFICATION OF GRADE CROSSING PROBLEMS.

TOLL FREE TELEPHONE NUMBER.—The Secretary of Transportation shall designate not later than one year after the date of enactment of this Act, and thereafter maintain an emergency notification system utilizing a toll free "800" telephone number that can be used by the public to convey to railroads, either directly or through public safety personnel, information about malfunctions or other safety problems at railroad-highway grade crossings.●

ADDITIONAL COSPONSORS

S. 359

At the request of Mr. DECONCINI, the name of the Senator from Maine [Mr. MITCHELL] was added as a cosponsor of S. 359, a bill to require the Secretary of Treasury to mint coins in commemoration of the National Law Enforcement Officers Memorial, and for other purposes.

S. 1329

At the request of Mr. D'AMATO, the name of the Senator from Delaware [Mr. BIDEN] was added as a cosponsor of S. 1329, a bill to provide for an investigation of the whereabouts of the United States citizens and others who have been missing from Cyprus since 1974.

S. 1677

At the request of Mr. HATFIELD, the name of the Senator from Wisconsin [Mr. FEINGOLD] was added as a cosponsor of S. 1677, a bill to prohibit United States military assistance and arms transfers to foreign governments that are undemocratic, do not adequately

protect human rights, are engaged in acts of armed aggression, or are not fully participating in the United Nations Register of Conventional Arms.

S. 2068

At the request of Mr. PRESSLER, the name of the Senator from Minnesota [Mr. WELLSTONE] was added as a cosponsor of S. 2068, a bill to authorize the construction of the Lewis and Clark Rural Water System and to authorize assistance to the Lewis and Clark Rural Water System, Inc., a nonprofit corporation, for the planning and construction of the water supply system, and for other purposes.

S. 2183

At the request of Mrs. HUTCHISON, the name of the Senator from Kansas [Mrs. KASSEBAUM] was added as a cosponsor of S. 2183, a bill to require the Secretary of the Treasury to mint coins in commemoration of the 50th anniversary of the signing of the World War II peace accords on September 2, 1945.

S. 2272

At the request of Mr. DECONCINI, the name of the Senator from Utah [Mr. HATCH] was added as a cosponsor of S. 2272, a bill to amend chapter 28 of title 35, United States Code, to provide a defense to patent infringement based on prior use by certain persons, and for other purposes.

S. 2273

At the request of Mr. HOLLINGS, the name of the Senator from Mississippi [Mr. LOTT] was added as a cosponsor of S. 2273, a bill to reduce Government spending by $100,000,000,000 each fiscal year until a balanced Federal budget is achieved.

S. 2283

At the request of Mr. SHELBY, the name of the Senator from South Carolina [Mr. HOLLINGS] was added as a cosponsor of S. 2283, a bill to amend title XVIII of the Social Security Act to provide for coverage of prostate cancer screening and certain drug treatment services under part B of the Medicare Program, to amend chapter 17 of title 38, United States Code, to provide for coverage of such screening and services under the programs of the Department of Veterans Affairs, and to expand research and education programs of the National Institutes of Health and the Public Health Service relating to prostate cancer.

S. 2347

At the request of Mr. SASSER, the name of the Senator from Pennsylvania [Mr. SPECTER] was added as a cosponsor of S. 2347, a bill to require the Secretary of the Treasury to mint coins in commemoration of the 150th anniversary of the founding of the Smithsonian Institution.

S. 2380

At the request of Mr. METZENBAUM, the name of the Senator from Rhode Island [Mr. PELL] was added as a cosponsor of S. 2380, a bill to encourage serious negotiations between the major league baseball players and the owners of major league baseball in order to prevent a strike by the players or a lockout by the owners so that the fans will be able to enjoy the remainder of the baseball season, the playoffs, and the World Series.

SENATE JOINT RESOLUTION 178

At the request of Mr. DOMENICI, the name of the Senator from Mississippi [Mr. LOTT] was added as a cosponsor of Senate Joint Resolution 178, a joint resolution to proclaim the week of October 16 through October 22, 1994 as "National Character Counts Week."

SENATE JOINT RESOLUTION 209

At the request of Mr. COCHRAN, the names of the Senator from Maine [Mr. MITCHELL] and the Senator from Michigan [Mr. RIEGLE] were added as cosponsors of Senate Joint Resolution 209, a joint resolution designating November 21, 1994, as "National Military Families Recognition Day."

SENATE CONCURRENT RESOLUTION 66

At the request of Ms. MIKULSKI, the name of the Senator from Massachusetts [Mr. KENNEDY] was added as a cosponsor of Senate Concurrent Resolution 66, a concurrent resolution to recognize and encourage the convening of a National Silver Haired Congress.

AMENDMENT NO. 2404

At the request of Mr. EXON the name of the Senator from Mississippi [Mr. LOTT] was added as a cosponsor of Amendment No. 2404 intended to be proposed to S. 1822, a bill to foster the further development of the Nation's telecommunications infrastructure and protection of the public interest, and for other purposes.

AMENDMENT NO. 2561

At the request of Mr. DODD the name of the Senator from Illinois [Ms. MOSELEY-BRAUN] was added as a cosponsor of Amendment No. 2561 proposed to S. 2351, an original bill to achieve universal health insurance coverage, and for other purposes.

ADDITIONAL STATEMENTS

BUILDING FOR PEACE

• Mr. MACK. Mr. President, the Middle East peace process has progressed at a truly unbelievable pace over the course of the past year. We were all moved when Israeli Prime Minister Yitzhak Rabin and PLO Chairman Yasser Arafat came to the White House last September 13 to sign the historic Declaration of Principles.

Since then, agreements have been signed between Israel and the PLO on April 29 to coordinate their economic relationships and on May 4 to facilitate Israeli withdrawal from Jericho and Gaza. The agreements with the PLO set the stage for King Hussein to come to Washington to sign an agreement ending Jordan's state of belligerency with Israel.

Talks are underway to determine if Israel will be able to reach an agreement with Syria. Hopefully, these talks will eventually lead to another historic signing in Washington.

Mr. President, these diplomatic accomplishments are great and will, hopefully, set the stage for real peace in the region. But diplomatic agreements can only provide the outlines of peace. The real test will come in the daily lives of the people who live there. Israeli citizens and Palestinians and Jordanians must see that the peace will benefit their daily lives for this process to have any hope of ultimate success.

To a large degree, this will be measured in improvements in the well-being of the lives of these people. The first step in this will be to improve the economic conditions and create stability and prosperity in the territories.

Two steps have been undertaken to accomplish these goals.

First, those nations with a stake in this peace process, led by the United States, have pledged funds to the Palestinian Authority to help them build infrastructure projects—roads, telecommunications, housing, waste removal systems and water projects.

Second, efforts are underway to assist the Palestinians to build their private sector. We must focus upon the private sector so that the Palestinians do not come to rely in the long-term upon international contributions. They must be able to develop their own business ventures capable of providing meaningful employment for their people.

Only when the underlying socioeconomic discontent is addressed at the grassroots level, can the peace process flourish. Without the basic dignity that jobs provide, people could easily continue to fall prey to the wishes of extremists.

A new organization called Builders for Peace was established last November in order to promote these economic objectives. This nonprofit organization was set up to foster relationships between the United States and Palestinian commercial communities.

Builders for Peace is an important contribution to help develop the economy of the region and assist in the overall peace process.

Builders for Peace is a unique organization. It has two copresidents, former Congressman Mel Levine and Dr. James Zogby, the president of the Arab-American Institute. These two former adversaries are now working together to promote American investments in the Palestinian territories.

The organization has boards of directors and advisers comprised of leaders of the American-Arab and Jewish communities. Again, many of these people have been adversaries for years and now they are also working together.

Builders for Peace has helped to stimulate a number of projects that will soon be underway. These projects will serve as tangible evidence of the support for the peace process by the American private sector.

Mr. President, Builders for Peace is an organization that deserves our support, just as it has the support of this administration, the Israel Government, and the PLO leadership.

Its potential to assist the peace process is enormous and I hope that the Congress will lend its support to these endeavors.●

AFFORDABLE HEALTH CARE NOW ACT—S. 1533

● Mr. LOTT. Mr. President, I would like to take this opportunity to introduce a refined version of the Affordable Health Care Now Act. I ask to include an analysis of the changes made in S. 1533.

The material follows:

CHANGES IN S. 1533

Language providing clarification and additional standards governing purchasing groups.

Eliminate pre-existing condition exclusion if employee elects coverage when first eligible.

Update insurance reform language, moving away from rating band approach to community rating and using basically the consensus standards developed by the insurance industry, large and small. Include language allowing discounts for wellness programs, etc.

Require small employers of 50 or fewer employees who self-insure to have re-insurance (stop-loss) policies. Allow small self-insuring employers to be included in state-established risk adjustment programs.

Require insurance companies currently serving the individual market to serve all individuals.

Include "patient protection" standards for managed-care plans.

Increase funding for rural care programs.

Eliminate the Federal retirement age increase section of the bill.

Standards for long-term care.

Allow Medicare recipients a greater choice of health plans.

Establish marketing standards setting forth information insurance companies must make available regarding their plans.

Adjustments in anti-trust reform language.

Eliminate the following tax breaks for long-term care: Tax-free exchanges of life insurance for LTC policies. Use of IRA and 401(k) funds for LTC insurance. Permit exclusion for accelerated death benefits.

Limit SSI and Medicaid for resident aliens.

Repeal duplicative vaccine program.

Limit SSI for drug abusers.

Extend current law setting Medicare Part B premiums to cover about 25% of average benefits (sunsets in 1999).

Extend current law requirements for Medicare secondary payers (sunsets of 1996).

Establish a program of assistance for low-income individuals, to be operated through the states. Priority will be given to children from families below 185% of poverty, pregnant women below 150% of poverty, and other individuals below 150% of poverty, in that order. Federal assistance would amount to approximately $90 billion over 10 years and would be financed by the offsets in the bill plus a 25% reduction in disproportionate share payments.

AFFORDABLE HEALTH CARE NOW ACT

IMPROVED ACCESS TO AFFORDABLE HEALTH CARE COVERAGE

I. All employers must offer, but are not required to pay for, insurance to their employees.

II. Small group insurance reform:

A. Insurers must offer small employers standard and catastrophic plans with an actuarial value range as determined by the National Association of Insurance Commissioners. They may also offer a Medisave Plan.

B. Small ground is defined as employers with between 2-50 employees.

C. Risk pools would be established to spread insurer risks.

III. Employee Insurance Security:

A. Employees cannot be excluded from insurance coverage because of preexisting conditions.

B. Employees are assured of continued insurance coverage when changing jobs.

IV. Promoting More Affordable Insurance Coverage:

A. Increase tax deductions for the self-employed to 100% and provide deductions for employees who purchase their own insurance.

B. Exempt all group health plans from state benefit mandates.

C. Prohibit state restrictions on managed care.

D. Establish standards and incentives for multi-employer insurance purchasing groups.

E. Eliminate current IRS regulatory barriers which prevent employer groups from being able to offer tax-exempt health insurance.

V. Family Medical Savings Accounts (Medisave).

VI. Reforming Medicaid:

A. Permit states to utilize private insurance for Medicaid beneficiaries.

B. Permit uninsured people to buy-in to the Medicaid program, with graduated subsidies up to 200% of poverty.

VII. Expansion of Community Health Center Program.

VIII. Expanded Rural Health Care Services.

IX. Long-term Care.

HEALTH CARE COST CONTAINMENT

I. Malpractice Reform.

II. Administrative Reform:

A. Streamlined Paperwork.

B. Electronic Billing.

C. Merge Medicare Parts A and B.

III. Anti-trust Reforms.

IV. Anti-fraud provisions.

V. State Medicaid flexibility.

THE AFFORDABLE HEALTH CARE NOW ACT, S. 1533, REAL REFORM, THE COMMONSENSE WAY

IMPROVES ACCESS TO AFFORDABLE HEALTH CARE COVERAGE

Insurance Security:

Employees are assured access to affordable health insurance through their employer.

Employees cannot be excluded from insurance coverage because of pre-existing conditions.

Employees are assured of continued insurance coverage when changing jobs.

Bridges the gap for low-income workers and early retirees by allowing States to establish group insurance plans available for purchase, with subsidies for the low income.

Promoting More Affordable Insurance:

Encourages and makes it possible for employers to obtain affordable health coverage through group purchasing arrangements.

Requires insurers who sell in the small group market to offer health plans, including a Standard Plan, Catastrophic plan, and a Medisave plan, to all companies who employ 2 to 50 employees. These plans must meet a minimum coverage level as determined by the National Association of Insurance Commissioners.

Limits the insurance premium rate variations charged to small businesses and will limit the annual increases in insurance premium rates.

Encourages group purchasing arrangements by easing paperwork and other regulatory burdens and by eliminating the current IRS regulatory barriers which prevent employer groups (the American Farm Bureau, for example) from being able to offer health insurance.

Tax Fairness:

Increases the tax deduction for self-employed individuals to 100 percent from 25 percent.

Provides 100 percent tax deductibility of the cost of health insurance premiums for all individuals who purchase their own insurance.

Medical Savings Accounts (Medisave):

Allows tax-free deposits to Medisave Accounts to reimburse medical expenses and pay for a long-term catastrophic, Medigap and Medicare premiums.

Reforming Medicaid:

Permits states to use private insurance for Medicaid beneficiaries.

Permits families with incomes up to 200 percent of poverty to buy-in to the Medicaid program.

Expands the Community Health Center Program as the disadvantaged Americans will have access to vital preventive and primary care.

Expands Rural Health Care Services:

Improves emergency medical services in rural America.

Establishes Rural Emergency Access Care Hospitals.

Expands Long Term Care Options.

Provides the same tax benefit for long term care insurance as for other insurance plans.

Allows Americans, the option of using IRA's, 401(k) plans, and life insurance—tax free—to purchase long term care insurance.

Allows states to offer seniors asset protection plans.

PUTS THE BRAKES OF SKYROCKETING COSTS

Reforms the Malpractice and Product Liability System to limit frivolous lawsuits, adequately compensate victims, and reduce defensive medicine costs.

Requires Administrative Reforms to establish a single, standard claim form and encourage the development electronic billing.

Increases enforcement of current laws and closes loop-holes to prevent medical fraud and abuse.

Creates personal Medical Savings Accounts, integrated into the insurance system, that allow you and your doctor to determine the most appropriate course of treatment.

Allows States to establish managed care plans for Medicaid beneficiaries.

Reforms antitrust laws to allow sharing of facilities and equipment by providers, thus reducing overhead.●

MEASURE READ THE FIRST TIME—S. 2396

Mr. LAUTENBERG. Mr. President, I understand that S. 2396, the Affordable

Health Care Now Act, introduced earlier today by Senator LOTT, is at the desk.

The PRESIDING OFFICER. The Senator is correct.

Mr. LAUTENBERG. Mr. President, I ask for its first reading.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

A bill (S. 2396), entitled the "Affordable Health Care Now Act."

Mr. LAUTENBERG. Mr. President, I ask now for its second reading; and, on behalf of the Republican leader, I object.

The PRESIDING OFFICER. Objection is heard.

The bill will be read for the second time on the next legislative day.

ORDERS FOR TOMORROW

Mr. LAUTENBERG. Mr. President, on behalf of the majority leader, I ask unanimous consent that when the Senate completes its business today, it stand in recess until 9:30 a.m., Wednesday, August 17; that following the prayer, the Journal of proceedings be deemed approved to date and the time for the two leaders reserved for their use later in the day; that there then be a period for morning business, not to extend beyond 10 a.m., with Senators permitted to speak therein for up to 5 minutes each, with Senator BENNETT recognized to speak for up to 10 minutes and Senator CAMPBELL for up to 5 minutes; and that at 10 a.m., the Senate resume consideration of S. 2351, the Health Security Act.

The PRESIDING OFFICER. Without objection, it is so ordered.

RECESS UNTIL TOMORROW AT 9:30 A.M

Mr. LAUTENBERG. Mr. President, if there is no further business to come before the Senate today, I now ask unanimous consent that the Senate stand in recess, as previously ordered.

There being no objection, the Senate, at 10:12 p.m., recessed until Wednesday, August 17, 1994, at 9:30 a.m.

NOMINATIONS

Executive nominations received by the Senate August 16, 1994:

NATIONAL FOUNDATION ON THE ARTS AND THE HUMANITIES

JORGE M. PEREZ, OF FLORIDA, TO BE A MEMBER OF THE NATIONAL COUNCIL ON THE ARTS FOR A TERM EXPIRING SEPTEMBER 3, 1998, VICE NINA BROCK, TERM EXPIRED.

STATE JUSTICE INSTITUTE

JOSEPH FRANCIS BACA, OF NEW MEXICO, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE STATE JUSTICE INSTITUTE FOR A TERM EXPIRING SEPTEMBER 17, 1995, VICE JAMES DUKE CAMERON, TERM EXPIRED.

ROBERT NELSON BALDWIN, OF VIRGINIA, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE STATE JUSTICE INSTITUTE FOR A TERM EXPIRING SEPTEMBER 17, 1995, VICE CARL F. BIANCHI, TERM EXPIRED.

JENNIFER CHANDLER HAUGE, OF NEW JERSEY, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE STATE JUSTICE INSTITUTE FOR A TERM EXPIRING SEPTEMBER 17, 1995, VICE SANDRA A. O'CONNOR, TERM EXPIRED.

FLORENCE K. MURRAY, OF RHODE ISLAND, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE STATE JUSTICE INSTITUTE FOR A TERM EXPIRING SEPTEMBER 17, 1995, VICE MALCOLM M. LUCAS, TERM EXPIRED.

THE JUDICIARY

ELAINE F. BUCKLO, OF ILLINOIS, TO BE U.S. DISTRICT JUDGE FOR THE NORTHERN DISTRICT OF ILLINOIS, VICE JOHN A. NORDBERG, RETIRED.

DAVID H. COAR, OF ILLINOIS, TO BE U.S. DISTRICT JUDGE FOR THE NORTHERN DISTRICT OF ILLINOIS, VICE ILANA DIAMOND ROVNER, ELEVATED.

ROBERT W. GETTLEMAN, OF ILLINOIS, TO BE U.S. DISTRICT JUDGE FOR THE NORTHERN DISTRICT OF ILLINOIS, VICE JOHN F. GRADY, RETIRED.

PAUL E. RILEY, OF ILLINOIS, TO BE U.S. DISTRICT JUDGE FOR THE SOUTHERN DISTRICT OF ILLINOIS, VICE A NEW POSITION CREATED BY PUBLIC LAW 101-650, APPROVED DECEMBER 1, 1990.

IN THE ARMY

THE FOLLOWING-NAMED OFFICERS FOR PROMOTION IN THE RESERVE OF THE ARMY, UNDER THE PROVISIONS OF TITLE 10, U.S.C., SECTIONS 593(A) AND 3383:

To be colonel

THOMAS J. ANDERSON xxx-xx-x...
AUGUST A. BAILEY xxx-xx-x...
RONALD A. BAKER xxx-xx-x...
KENNETH PENTTILA xxx-xx-xx...
EDWARD ZGLENSKI xxx-xx-x...

CHAPLAIN CORPS

To be colonel

STEPHEN R. BARTELT xxx-xx-xx...
JUNIOR J. BRELAND xxx-xx-xx...
RICHARD N. MAUGHAN xxx-xx-x...

MEDICAL CORPS

To be colonel

RICKY D. WILKERSON xxx-xx-x...

MEDICAL SERVICE CORPS

To be colonel

THOMAS C. HEINEMAN xxx-xx-x...
ROY D. MCKINNEY xxx-xx-x...

To be lieutenant colonel

ROBERT B. MORGAN, xxx-xx-x...

To be lieutenant colonel

DOUGLAS B. BOCK xxx-xx-x...
RITA M. BROADWAY xxx-xx-x...
FREDERICK G. BROMM xxx-xx-x...
PHILLIP R. BURCH xxx-xx-x...
MICHAEL W. COLBERT xxx-xx-x...
JOHN D. CULP xxx-xx-x...
CRAIG DEUTSCHENDORF xxx-xx-x...
MICHAEL R. EYRE xxx-xx-x...
CLARENCE C. FREELS xxx-xx-xx...
THOMAS E. GORSKI xxx-xx-x...
MICHAEL C. GRAY xxx-xx-x...
ELLIS E. JOHNSON xxx-xx-xx...
GARY W. JONES xxx-xx-x...
WILLIAM C. JONES xxx-xx-x...
WILLIAM KIRKLAND xxx-xx-x...
JAMES E. LOUIS xxx-xx-xx...
CHARLES F. LUCE xxx-xx-x...
RICHARD L. NORMAN xxx-xx-x...
PHILLIP G. PICCINI xxx-xx-xx...
ALFRED E. POOLE, xxx-xx-x...
JAMES W. RAFFERTY xxx-xx-xx...
DALE P. SAYSET xxx-xx-xx...
MATTHEW STALLINGS xxx-xx-x...
RICHARD M. TABOR xxx-xx-x...
JOHNNY R. TREVINO xxx-xx-x...
JAMES W. UTLEY xxx-xx-x...

VETERINARY CORPS

To be lieutenant colonel

MARK D. MARKS xxx-xx-x...

THE FOLLOWING-NAMED OFFICERS FOR PROMOTION IN THE RESERVE OF THE ARMY, UNDER THE PROVISIONS OF TITLE 10, U.S.C., SECTIONS 593(A) AND 3383:

To be colonel

MICHAEL FOSS xxx-xx-x...
TERRENCE J. NELSON xxx-xx-xx...
PAUL M. SHINTAKU xxx-xx-x...
ROBERT R. SIMMONS xxx-xx-x...
CLIFFORD W. WHALL xxx-xx-x...
GLENN K. YOUNG xxx-xx-x...

ARMY NURSE CORPS

To be colonel

SARAH L. GILES xxx-xx-x...
CHRISTINE A. WYND xxx-xx-x...

To be lieutenant colonel

TERRY K. CORSON xxx-xx-x...
REBECCA A. COULTER xxx-xx-x...
SHANNON L. GOMES xxx-xx-x...
DENNIS R. KAI xxx-xx-x...
BRADFORD M. KARD xxx-xx-x...
JERRY L. LAND, JR. xxx-xx-xx...
GREGORY W. LEONG xxx-xx-x...
JAMES B. MALLORY xxx-xx-x...
JOHN C. MCCORMICK xxx-xx-x...
SHARON MIYASHIRO xxx-xx-x...
STANLEY SHURMANTINE xxx-xx-x...
JAMES B. TAYLOR, JR. xxx-xx-x...
JOSE USON, JR. xxx-xx-xx...